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Halfway Houses and Long-Term Community Residences for the Mentally Ill, United States, 1976

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I. INTRODUCTION

Halfway houses have proven to be durable and effective programs assisting mentally disabled persons in the transition from hospital to community life. Further, both freestanding halfway houses and affiliated halfway houses (which offer services as an adjunct to other, more extensive mental health programs) are increasingly used as alternatives to institutional care. In 1976, halfway-house programs reported that they served both a large number of hospital expatients and a growing number of clients who entered the halfway house directly from the community. Some entrants had never been hospitalized for mental illness; others who had been hospitalized and discharged in the past chose a halfway house or other community residential program for further treatment. Without halfway houses thousands of persons who might have been hospitalized — or received no residential service at all — have been able to reside in the community while receiving supportive and rehabilitative care.

The following report draws upon a decade of sample surveys and inventories of halfway-house programs for the mentally disabled. These studies — conducted by the Survey and Reports Branch of the Division of Biometry and Epidemiology, National Institute of Mental Health (NIMH), Rockville; Horizon House Institute for Research and Development, Philadelphia; and other researchers — have focused on the geographical distribution, staffing patterns, client characteristics, costs, and services of transitional and nontransitional residential facilities that provide live-in staff or around-the-clock supervision for persons who have suffered a mental illness.

In the early days of the halfway-house movement, the works of Henry Wechsler (1960), Sherman Ghan (1962), and Harold and Charlotte Raush (1968) documented the development of halfway houses as part of the accelerating trend toward community mental health programs. Table 1 provides a partial listing of studies of halfway houses and community residences in the United States from 1960 to 1976. The halfway house, which emerged as an important link between the hospital and the community, increasingly serves as a residential setting for community mental health clients who might otherwise require hospitalization. While no complete enumeration of facilities has yet been conducted, surveys and reports indicate rapid expansion in the number of halfway-house programs. Paralleling the decline of hospital inpatient populations, this expansion is associated with a growing awareness of the need for community-based follow-along and residential alternatives to institutional service.

Table 1. Number of halfway houses and community residences in the United States identified in selected studies

Researchers	Year	Number of halfway houses	
		Psychiatric	Alcoholism
Henry Wechsler[a/]	1960	10	-
Sherman Ghan[b/]	1962	13	-
Harold and Charlotte Raush[c/]	1963	40	-
Glasscote et al.[d/]	1969	128	-
Sidney Cahn[e/]	1969	-	120
NIMH surveys[f/]	1969	241[g/]	216[h/]
	1971	196[i/]	337[j/]
	1973	209[i/]	597[j/]
	1976	228[k/]	- [l/]
Horizon House Institute[m/]	1974	140	214

[a/] Wechsler, H. Halfway houses for former mental patients: A survey. *Journal of Social Issues*, 16(2):20-26, 1960.

[b/] Ghan, S.L. "The Halfway House: A Transitional Facility for the Rehabilitation of the Mentally Ill." Unpublished master's thesis, School of Social Work, University of British Columbia, 1962.

[c/] Raush, H., and Raush, C. *The Halfway House Movement: A Search for Sanity*. New York: Appleton-Century-Crofts, 1968.

[d/] Glasscote, R.M.; Gudeman, J.E.; and Elpers, R. *Halfway Houses for the Mentally Ill*. Washington, D.C.: JIS-APA, 1971.

[e/] Cahn, S. Alcoholism halfway houses: Relationships to other programs and facilities. *Social Work*, 14:50-60, Apr. 1967.

[f/] Halfway house surveys conducted by the Division of Biometry and Epidemiology, NIMH.

[g/] The 241 psychiatric halfway houses included 134 which served only the mentally ill and 107 which served the mentally ill and others of which a large proportion also served alcoholics.

[h/] Includes facilities which served only alcoholics.

[i/] Includes only facilities which serve primarily the mentally ill although others may be admitted on occasion.

[j/] Includes only facilities which serve primarily alcoholics although others may be admitted on occasion.

[k/] The 1976 Division of Biometry and Epidemiology, NIMH, Inventory of Halfway Houses and Community Residences (long-term) included 133 adult transitional facilities (halfway houses), 28 facilities for children and adolescents, and 67 adult long-term facilities.

[l/] For the NIMH 1976 Inventory of Halfway Houses and Community Residences, programs primarily serving alcoholics were not surveyed.

[m/] In 1974, Horizon House Institute surveyed 472 halfway houses including 140 serving primarily the mentally ill or emotionally disturbed.

II. OVERVIEW

The 228 halfway houses and community residences responding to the 1976 NIMH inventory admitted an estimated 8,736 persons in 1975 and provided a total of 7,965 beds. Both the number of beds and the number of admissions per 100 beds substantially increased since 1973.

The most common in-house services included individual therapy and group counseling (provided by about three-fourths of all programs), group meetings, and recreational services. Facilities were often allied with other mental health, health, and rehabilitation programs. These "external" agencies provided medical, vocational, and educational services.

The number of residents per staff member was found to be related to the number and type of services provided. For example, facilities with more in-house counseling services had a higher ratio of staff to clients than facilities offering fewer such services.

Service patterns and their associated staffing requirements were found to significantly affect total facility costs and per diem expenditures: The greater the number of in-house services, the higher the per diem cost. It should be noted that the variable facility size, as measured by the number of residents, did not have an independent effect on cost; that is, economies of scale were not apparent.

Services and costs were also found to vary according to the transitional focus of the facility. Nontransitional facilities offering relatively long-term residence reported lower costs and fewer in-house counseling or therapeutic services than short-term facilities. Typically, nontransitional programs tend to be larger, to charge less, and to operate under a for-profit auspice.

It should be emphasized that the existing data base for these findings is limited. As noted in the methodological discussion in the concluding section, the facilities reported on in this study represent only a sample of the total array of residential services. Group homes, foster programs, and domiciliary care programs were not the foci of this NIMH inventory. Further, many halfway houses and community residences which had been included in earlier surveys were deleted because their programs were identified as components of other mental health organizations (e.g., federally funded community mental health centers) and their data were reported through the Inventories submitted by these other organizations. Because the data included in this report neither fully enumerate a specific type of facility nor constitute an altogether unbiased sample, population rates cannot readily be estimated.

III. ISSUES IN THE DEVELOPMENT OF COMMUNITY RESIDENCES

Richard Budson in *The Psychiatric Halfway House: A Handbook of Theory and Practice*, characterizes the halfway-house movement as a response to "four basic deficiencies of the traditional large institution": (1) largeness, (2) universal medical model (where the patient is considered sick on a 24-hour-a-day basis), (3) a closed society (with a tightly ordered punitive social system), and (4) isolation from the community. To address these four problems, halfway-house design has concentrated on smallness, a family model, an open setting, and integration with the community. Yet, just as there are many types of families in any society, there are many types of halfway-house programs. Some community residences embody essentially parental roles: *In loco parentis* is often an explicit policy in halfway houses for juveniles. Some self-help programs are organized on the basis of peer or sibling relationships. In cooperative member associations, clients and staff share decisionmaking roles. Whatever the specific attributes of individual halfway houses, after two decades during which State hospital rolls diminished as community-based treatment and residential programs developed, tens of thousands of mentally disabled persons now reside in community-based facilities across the country.

The facilities responding to recent surveys reported increasing demand for their services as an alternative to institutional care. Total available beds (including estimates for facilities which failed to report in 1973, 1976, or both) rose from 7,089 in 1973, to 7,965 in 1976. However, growth of community-based facilities has not met the expectations of their early proponents. The moderately sized 15- to 25-bed facility, with in-house professional and paraprofessional staff providing 24-hour supervision, support, and rehabilitation services, has become a familiar modality. Conservatively estimated, 300 such facilities for the mentally disabled exist, but the still modest number of such community residences has lagged behind the rising demand for noninstitutional care. As a result, non-halfway house community residences for the mentally ill have burgeoned.

Two radically different types of programs have emerged. On the one hand, large-scale facilities, often converted hotels such as the single room occupancy hotels (SRO) of New York City and Chicago, have absorbed tens of thousands of former mental hospital clients. Although they do not return patients fully to normal community life, these facilities provide at least minimally supportive residential care for many former mental hospital patients. The debate regarding the adequacy and humanity of such large-scale urban programs is very much unresolved. As Budson (1978) has observed:

> . . .(I)nadequate development of proper rehabilitative facilities in the community has had serious consequences for patients. In several parts of the country there has already been a sudden influx of discharged patients into unprepared communities. With no prearranged residential program designed to meet their rehabilitative needs, patients have too often drifted into blighted urban areas, into single occupancy hotels, living in isolation and without meaningful activity. Ghettos of former mental patients tend to form in the most undesirable areas. In this setting, deterioration is the rule, with the outcome for the patient too frequently suicide, destructive behavior, or return to intense withdrawal. In addition, the ex-patient is victimized by the predators of society who frequent the same parts of the urban jungle. This situation has attained high visibility in the local community through an attentive press.

Paralleling the development of large long-term facilities in urban areas, a second type of emerging residential facility uses small group homes, foster homes, board and care programs, and personal care homes. California alone reports over a thousand such residences, and it is estimated that about one-third of their clients are mentally disabled (Segal 1978).

These long-term and short-term small facilities are perhaps the most rapidly developing community residential care modalities. They most often offer minimal supportive and rehabilitative in-house services and may link their clients to programs provided by external agencies. However, even these general conclusions must be only cautiously

advanced, for little reliable information is available on the characteristics of either the large or small residential arrangements. To avoid confusion among the major types of facilities referenced here, most of the statistical displays differentiate short-term from long-term and child-oriented from adult-oriented programs.

IV. CLASSIFICATION OF RESIDENTIAL PROGRAMS

DEFINITIONS OF RESIDENTIAL FACILITIES SURVEYED RECENTLY

By 1969, when Raymond Glasscote and his associates were conducting studies for *Halfway Houses for the Mentally Ill*, (1971), statistical reports for halfway houses had become practicable. With a sample of 128 facilities, researchers could go beyond case studies of this modality. At the same time, NIMH introduced a new inventory form that systematically surveyed halfway houses for the mentally ill and the alcoholic. Table 1 shows the number of facilities responding to each of the four NIMH surveys conducted between 1969 and 1976. The data set comprising the two most recent NIMH inventories (1973 and 1976), together with additional information collected by Horizon House Institute (1974 and 1977), serves as the basic information package for this report.

NIMH has been surveying halfway houses across the Nation since 1969. For the 1976 inventory, NIMH determined that it would be appropriate to add other residences to the now "traditional" halfway house in the survey of community programs for the mentally disabled. Thus, a new category was added to the inventory, and the inventory itself was changed to one of psychiatric halfway houses *and* community residences. A definition (relatively unchanged since 1971) was employed which stated that a psychiatric halfway house is:

> A non-medical residential facility with three or more beds which has round-the-clock or live-in staff and provides room, board, supervised living, and other supportive or rehabilitation services to people with *mental health problems*. The program of the facility is transitional in nature, designed either to provide an alternative to inpatient care, to shorten the length of hospitalization, or to assist clients in preparing for independent living following discharge from an inpatient facility.

Most (77 percent) of the facilities responding to the 1976 questionnaire classified themselves as halfway houses, and many of them had participated in earlier inventories of halfway houses conducted by NIMH. The 1976 inventory also sought responses from community residential programs providing long-term housing and support for the mentally disabled. A community residence is defined as:

> A non-medical residential facility with three or more beds which has round-the-clock or live-in staff who provide supervision and support on a long-term basis to people with *mental health problems*.

These two definitions were intended to highlight the transitional nature of halfway houses as distinguished from the long-term care focus of certain other community residential programs. Thus, the definition for community residences excludes mention of rehabilitation services. Some facilities with long-term programs *and* rehabilitation services indicated that they should be considered halfway houses. This question is discussed in Methodological Notes, "Toward a Typology of Residential Programs," (page 00) a general review of issues that also considers the problem of defining community residences that are not (or choose not to be called) halfway houses, but that nonetheless provide transitional and short-term service.

Although facilities have self-reported their classification as "halfway house" *or* "community residence," an examination of indices of utilization, staffing, and licensure suggests a more complex picture. Therefore, we have developed a classification procedure based upon:

(1) the number of admissions per 100 beds,
(2) the proportion of clients in residence for over 6 months, and
(3) restriction of clientele to juveniles.

Using this procedure, we reclassified facilities into three types according to their provision of transitional or long-term care and their inclusion or exclusion of juveniles: children and adolescents, adult transitional, and adult nontransitional. As shown, selected indicators vary substantially for the three types. Table 2 lists 13 basic service, staffing, size, and other operating characteristics for facilities responding to the NIMH 1976 inventory.

Table 2. Selected characteristics of psychiatric halfway houses and community residences by type of facility: United States, 1976

Selected characteristics	Type of facility				Test of significance[d]
	All types	Children and adolescents	Adult transitional	Adult non-transitional	
Size:					
Mean number of beds per facility	35.3	11.7	16.9	78.1	F = 46.19 p <.001
Mean number of residents per facility	30.5	9.8	14.4	67.4	F = 49.09 p <.001
Staffing:					
Employed staff hours per resident/per week	14.4	21.9	14.8	9.9	F = 7.96 p <.001
Full-time persons employed per 100 residents	32.4	49.6	33.0	22.9	F = 8.17 p <.001
Services:					
Mean number of in-house counseling and therapy services per facility[a]	2.81	3.15	2.94	2.31	F = 3.91 p <.025
Mean number of external facilitative services per facility[b]	1.43	1.75	1.52	1.07	F = 1.62 p < n.s.
Mean number of external counseling and therapy services per facility[c]	0.72	0.25	0.96	0.36	F = 7.20 p <.001

Table 2. Selected characteristics of psychiatric halfway houses and community residences by type of facility: United States, 1976 (continued)

Selected characteristics	Type of facility				Test of significance[d]
	All types	Children and adolescents	Adult transitional	Adult non-transitional	
Utilization:					
Number of admissions per 100 beds	177	109	239	73	F = 29.34 p <.001
Proportion of total residents staying past six months	54%	55%	34%	89%	F = 147.70 p <.001
Other characteristics:					
Occupancy rate	85%	83%	84%	88%	F = 1.64 p < n.s.
Cost per resident per day	$18	$37	$16	$12	F = 24.54 p <.001
Proportion under proprietary auspice	25%	4%	10%	65%	x^2= 75.67 p <.001
Proportion licensed as halfway house	24%	25%	32%	8%	x^2= 13.72 p <.001
Number of facilities reporting	226	28	133	65	

[a] From 0 to 4 selected in-house counseling or therapeutic services could be provided.

[b] From 0 to 5 selected external facilitative services (e.g., vocational training or educational program) could be provided.

[c] From 0 to 3 selected external counseling or therapeutic services could be provided.

[d] F score derived through analysis of variance by Chi square.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

The large difference between adult transitional and adult nontransitional facilities in the proportion of residents staying over 6 months (average of 34 percent and 89 percent, respectively) is somewhat predetermined by the classification procedure, which was based partly on length of stay and admission rates. Yet the magnitude of the difference (55 percent) is not a function of the classification scheme alone; it reflects a dichotomy between the basic functions of transitional and long-term programs. This division is also observed in the large difference in the rate of admissions per 100 beds: Adult transitional facilities show a rate of new admissions three times the rate for nontransitional adult facilities (averages of 239 per 100 beds and 73 per 100 beds, respectively). These data reveal much more rapid turnover in the transitional facilities and also indicate that average length of stay in nontransitional facilities is well over 1 year.

While table 2 provides only a general overview of types of residential facilities, each characteristic is discussed more fully in later sections, which consider data on staff, service, cost, auspice, and client characteristics.

CONTINUING DEVELOPMENT OF RESIDENTIAL SERVICES

The emergence of new facilities since 1973 is revealed by data indicating that 57 percent of the facilities first reporting to the NIMH inventory in 1976 had opened in 1973 or later (see table 3). Types of auspices were distributed across government, citizen, and mental health organization sponsors; citizen, church, or civic groups started 17 facilities (see table 4). The initial auspice continues to be legally responsible for operating about two-thirds of the programs.

Half of the newly reporting programs planned additional residential sites. When specified, the number of sites to be developed generally ranged from 1 to 7, and one program planned 10 new sites. Most of the new facilities were to be started at an indefinite future date, but 15 respondents projected start-up within 6 months. Another 15 stated a year or more would be required before new openings.

Of the 94 reporting facilities, 30 (32 percent) experienced some type of opposition, most frequently from neighbors and the community (table 5). As did the 1974 survey conducted by Horizon House Institute, the 1977 survey found immediate neighbors the most frequent opponents. Program personnel responded to opposition with a number of strategies: use of the media, intervention by community leaders, formation of advocate groups, and educational activities such as house meetings, and open houses. Response to opposition required not only substantial personnel effort but also direct dollar outlays, with three programs estimating direct costs of at least $10,000. Efforts to neutralize or end opposition were successful in all but three cases, and only one facility had to be moved. Based on their own experience with opposition, program officials concluded that in contrast to using secretive or "low profile" strategies for introducing community residences, it was preferable to educate and involve neighbors and community residents in program development from the initial planning stages and to seek aid from key community leaders.

It should be noted that the data in table 5 do not adequately disclose the true extent of community opposition. Because only currently operating programs can respond to a survey, opposition that forces the closure of facilities goes unreported. For a more detailed discussion of the incidence of opposition and the strategies used in response, see "Community Response to Residential Services for the Psycho-Socially Disabled . . ." (Piasecki 1975).

Table 3. Number and percent distribution of psychiatric halfway houses and community residences participating for the first time in the NIMH inventory (1976) and resurveyed by Horizon House Institute in 1977, by year opened: United States, 1977 [a/]

Year opened	Number	Percent
Total resurveyed facilities.....	92	100%
1968 or earlier.....	21	23
1969-1970.....	7	8
1971-1972.....	11	12
1973-1974.....	38	41
1975-1976.....	15	16

[a/] New respondents to the NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences were 105 facilities. Ninety-two of these facilities reported the year they opened to Horizon House Institute in their resurvey of these facilities.

Table 4. Number and percent distribution of psychiatric halfway houses and community residences participating for the first time in the NIMH inventory (1976) and resurveyed by Horizon House Institute in 1977, by type of initial auspice: United States, 1977

Type of initial auspice	Number	Percent
Total reporting.....	86	100%
Citizen, church or civic group.	17	20
State government.....	15	17
Health institution.....	14	16
Mental health association or board.....	13	15
Parent program.....	13	15
Corporate interest.....	10	12
Community mental health center.	4	5

Source: Resurvey by Horizon House Institute of new respondents (N = 105) to the NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences. Nineteen facilities did not respond.

Table 5. Opposition to halfway houses and community residences participating for the first time in the NIMH inventory (1976) and resurveyed by Horizon House Institute in 1977: United States, 1977[a]

Opposition and strategy used to combat it	Number	Percent
Total reporting facilities	94	100%
Experienced opposition.....	30	32
Did not experience opposition..	64	68
Source of the opposition		
Total experiencing opposition..	30	99%
Neighbors, community groups....	18	60
Zoning officials.....	4	13
Both of the above.....	4	13
Other.....	4	13
Strategies used to ameliorate the opposition		
Total experiencing opposition..	30	99%
House meetings, visitation, education, neighbors.....	12	40
Intervention of town officials.	6	20
Tightened program operation....	4	13
Public media.....	1	3
Formed advocate group.....	1	3
Left area.....	1	3
Other.....	2	7
None or unknown.....	3	10

[a] New respondents to the NIMH 1976 survey were 105 facilities. Ninety-four of these facilities reported information regarding opposition to their program.

V. CHARACTERISTICS OF COMMUNITY-BASED RESIDENCES

SIZE

The more recently developed community-based residences show a clear trend toward smaller facilities. The median number of beds was 58 for nontransitional adult facilities started in 1968 or earlier, but 20 for similar facilities opened in 1975 or 1976 (table 6).

Transitional residences for adults show a similar steady decline in median size, from about 18 beds for facilities begun before 1971 to 11 or 12 beds for those opened since 1973. Children's facilities, typically smaller than those for adults, have followed the same general pattern: those started since 1973 report a median bed size of 8, considerably lower than the 12 to 15 beds for facilities opened earlier.

Size of community residences also varies by type of auspice. The proportion of proprietary facilities falling in the lowest size category (less than 30 beds) is nearly 44 percent, which is about half of the proportion for the other two auspice types (see table 7). For-profit facilities reported 19 large facilities (33 percent), a significantly larger proportion than reported by other auspices. In addition to having more beds, proprietary programs are typically older: Approximately 72 percent have been operating for at least 8 years. Government and nonprofit programs, on the other hand, reported 50.1 percent and 58.3 percent, respectively, of their total sites operating since 1968 or earlier (8 or more years in operation). Very few of these programs have more than 30 beds. There is a clear trend for more recently established facilities (less than 6 years old) to be operated by nonprofit agencies.

LENGTH OF STAY

The duration of community residential episodes is indicated by the percentage of clients who have been continuous residents for 6 months or longer. Although no average length of stay can be precisely computed from this single indicator, facilities housing relatively higher proportions of current clients with tenures of over 6 months are probably classifiable as long-term residences. (Section C in Methodological Notes, "Toward a Typology for Community-Based Residential Facilities," provides a detailed review of the implications of differential lengths of stay for facility size, structure, auspice, and services.)

At the 26 facilities serving children and/or adolescents, about 55 percent of the clients in residence during the sample period had been there for 6 months or longer. Similarly, facilities for adults reported that 54 percent of their resident clients had been served for at least 6 months. For both client groups, average length of stay increased with the size of the facility. The largest residential facilities, those with more than 75 beds, reported that over 83 percent of their current clients had been resident for at least 6 months (table 8). These data evoke an image of very large, long-term residential establishments that are programmatically distinct from smaller, shorter stay halfway houses and group homes.

AUSPICE

The NIMH inventory also records the type of organization legally responsible for the operation of the facility. Earlier studies have shown variations in auspice to be relevant to the facility's community acceptance and cost. Government-sponsored facilities (Piasecki 1975; Piasecki and Pittinger 1977) reported greater community opposition and higher costs than those under private agency auspices. Most programs included in the present survey that served children and adolescents were run by nonprofit organizations (table 9). Adult transitional facilities were similarly operated with only 11 percent under governmental auspice and 10 percent under proprietary control. Yet nontransitional facilities — those reporting relatively longer lengths of stay — showed an entirely different pattern: the majority (65 percent) were proprietary; the remainder (35 percent), nonprofit.

Table 6. Median bed size of psychiatric halfway houses and community residences by year opened and type of facility: United States 1976

Year opened	Type of facility			
	All types	Children and adolescents	Adult transitional	Adult non-transitional
	Median bed size			
1968 or earlier	20	12	18	58
1969-70.....	22	15	18	34
1971-72.....	15	12	15	27
1973-74.....	12	8	12	16
1975-76.....	11	8	11	20

Source: NIMH 1973 Inventory of Psychiatric Halfway Houses for Mentally Ill (N = 124) and resurvey by Horizon House Institute of new respondents (N = 105) to NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table 7. Percent distribution of halfway houses and community residences by bed count, type of auspice, and number of years in operation: United States, 1976

Type of auspice years in operation	Total	Number of beds		
		Less than 30 beds	30 to 75 beds	76 or more beds
Government				
Total.....	100.0%	85.8	7.1	7.1
Less than 3 years...	-	-	-	-
4-5 years.....	21.4	21.4	-	-
6-7 years.....	28.5	14.3	7.1	7.1
8-9 years.....	7.1	7.1	-	-
10 years and older..	43.0	43.0	-	-
Number of reporting facilities.....	(14)	(12)	(1)	(1)
Proprietary				
Total.....	100.0%	43.8	22.9	33.3
Less than 3 years...	7.1	3.5	1.8	1.8
4-5 years.....	14.0	10.5	-	3.5
6-7 years.....	7.1	5.3	1.8	-
8-9 years.....	17.6	7.0	5.3	5.3
10 years and older..	54.2	17.5	14.0	22.7
Number of reporting facilities.....	(57)	(25)	(13)	(19)
Nonprofit				
Total.....	100.0%	88.8	7.7	3.5
Less than 3 years...	7.6	7.6	-	-
4-5 years.....	20.2	17.4	2.8	-
6-7 years.....	13.9	13.9	-	-
8-9 years.....	16.0	14.6	0.7	0.7
10 years and older..	42.3	35.3	4.2	2.8
Number of reporting facilities.....	(144)	(128)	(11)	(5)

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table 8. Percent of residents staying for at least six months in different sizes and types of psychiatric halfway houses and community residences: United States, 1976

Type of facility	Number of facilities reporting	Number of residents	Number of beds			
			All sizes	Less than 30 beds	30 to 75 beds	More than 75 beds
			Percent of residents staying six months or more			
All facilities						
Facilities serving children and adolescents.....	26	1,420	54.6%	54.0%	69.6%	--%
Facilities serving adults.....	179	9,629	53.8	46.1	67.1	83.4

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table 9. Distribution of psychiatric halfway houses and community residences by type of auspice and type of facility: United States, 1976

Type of auspice	Type of facility							
	Total facilities		Children & adolescents		Adult transitional		Adult non-transitional	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total reporting facilities.....	226	100.0%	28	100.0%	133	100.0%	65	100.0%
Nonprofit agency or organization..	154	68.2	27	96.4	104	78.2	23	35.4
Government.....	15	6.6	-	-	15	11.3	-	-
Proprietary.....	57	25.2	1	3.6	14	10.5	42	64.6

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Clearly, the provision of services to the more chronic and less mobile mentally ill person has fallen to proprietary operators of nontransitional facilities. Although such facilities are frequently small in size (44 percent have fewer than 30 beds), almost one-third have 75 or more beds (see table 10). The proprietary nature of nontransitional facilities may reflect a reluctance on the part of the voluntary, nonprofit sector to serve more chronically disabled persons. Alternatively, new Federal and State housing supplementation programs may have opened new opportunities for the private sector to provide care for the unexpectedly large numbers of seriously disabled people for whom hospitalization is no longer deemed appropriate. Whatever its specific roots, a modality relatively unknown a decade ago has suddenly emerged as a primary caretaker of the chronically and seriously mentally disabled.

LICENSING

In her analysis of the NIMH 1973 halfway-house inventory, Cannon (1975) noted that many facilities were not licensed. In 1976, the situation was similar: About one-quarter of the 228 surveyed facilities held no license; another quarter of the facilities were licensed as halfway houses; and the remaining half were licensed as rooming houses, boarding homes, intermediate care facilities, hostels, or other types of residences. It is important to note that adult transitional facilities were significantly more likely to report holding a halfway-house license. Of the 90 adult transitional facilities with a license, 42 were licensed as halfway houses (table 11). While the nontransitional facilities were more likely to hold a license of some type (54, or 80 percent, were licensed), only five held a halfway-house license.

SEX RESTRICTIONS ON ADMISSION

Facilities serving adults are relatively less sex restrictive (admitting only males or only females) than facilities for children and youth. Over 80 percent of all adult programs, transitional and nontransitional, reported admitting both sexes, but fewer than 40 percent of the juvenile programs did (table 12). (It should be noted that stated policies may not reflect admission practices. Since the 1976 inventory deleted the 1973 questions on numbers of male and female clients, the prevalence of *de facto* sex restrictiveness cannot be determined.)

STAFFING PATTERNS

Another change in the NIMH 1976 inventory was the deletion of questions on the numbers and types of professional and nonprofessional staff employed by the facility.[1] Staffing questions retained in 1976 asked for the number of full-time and part-time regular staff, trainees, consultants, volunteers, and residents employed by the program, as well as the number of scheduled work hours for each category of staff for a sample week in February 1976.

Adult transitional facilities reported an average of about six full-time regular staff members and an average work week of about 41 hours (table 13). These facilities also employed about two part-time persons who averaged fewer than 15 hours during the sample week. At adult nontransitional facilities, the average work weeks were virtually identical (41 hours per week for full-time regular staff; 14 hours for part-time), but the average total number of regular staff was about twice the number for transitional programs. However, because nontransitional facilities usually serve more residents, the average number of staff hours per week is significantly lower than for transitional facilities.

Two indices of staffing — full-time staff hours per resident and full-time paid staff per 100 residents — show substantial differences between the three types of facilities. Facilities serving children and adolescents averaged almost 50 full-time staff per 100 residents, yielding about 22 hours of service per work week for each resident. For adult transitional facilities, rates were lower: 33 full-time staff per 100 residents and about 15 hours of scheduled staff time for each resident. The mean number of staff and level of staff time were still lower at adult nontransitional facilities which reported fewer than 10 staff hours per resident per week and fewer than 23 full-time staff for every 100 residents.

Staff hours per week per resident were found to vary according to the level of in-house counseling and therapy services available. Facilities that offered two or three of the four services listed in the section on resident services scheduled an average of 13.7 staff hours weekly. Facilities with all four in-house services reported almost 17 staff hours per resident per week (shown in figure A). Thus, staffing is closely related to level of in-house services. More staff and services probably indicate higher costs and a more transitional focus. These relationships are

[1] Since the majority of staff were reported as "other" in 1973, detailed breakouts by specialization tend to yield only marginal results.

Table 10. Distribution of psychiatric halfway houses and community residences by type of auspice and bed size: United States, 1976

Bed size	Type of auspice					
	Total		Proprietary		Nonproprietary	
	Number	Percent	Number	Percent	Number	Percent
Total facilities	228	100.0%	59	100.0%	169	100.0%
Less than 30..	176	77.2	26	44.1	150	88.8
30-74.....	26	11.4	14	23.7	12	7.1
75 or more....	26	11.4	19	32.2	7	4.1

Chi-square = 52.92 df = 2 $p < .001$

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table 11. Distribution of psychiatric halfway houses and community residences by licensure status: United States, 1976

Licensure status	Type of facility							
	Total facilities		Children & adolescents		Adult transitional		Adult non-transitional	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total reporting facilities.....	228	100.0%	28	100.0%	133	100.0%	67	100.0%
No license.....	57	25.0	1	3.6	43	32.3	13	19.4
Licensed.....	171	75.0	27	96.4	90	67.7	54	80.6
As halfway house.....	54	23.7	7	25.0	42	31.6	5	7.5
As other facility type..	117	51.3	20	71.4	48	36.1	49	73.1

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table 12. Distribution of psychiatric halfway houses and community residences by type of facility, licensure status, and sex groups admitted: United States, 1976

Licensure status/ sex restrictions on admission	Type of facility							
	All types		Children & adolescents		Adult transitional		Adult non-transitional	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total reporting facilities.....	226	100.0%	28	100.0%	133	100.0%	67	100.0%
Unlicensed fac....	57	25.2	1	3.6	43	32.3	13	20.0
Serve males only..	3	1.3	-	-	2	1.5	1	1.5
Serve females only	8	3.5	-	-	5	3.8	3	4.6
Serve both sexes..	46	20.4	1	3.6	36	27.0	9	13.9
Licensed fac.....	169	74.8	27	96.4	90	67.7	52	80.0
Serve males only..	21	9.3	10	35.7	7	5.3	4	6.2
Serve females only	22	9.7	8	28.6	10	7.5	4	6.2
Serve both sexes..	126	55.8	9	32.1	73	54.9	44	67.6

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

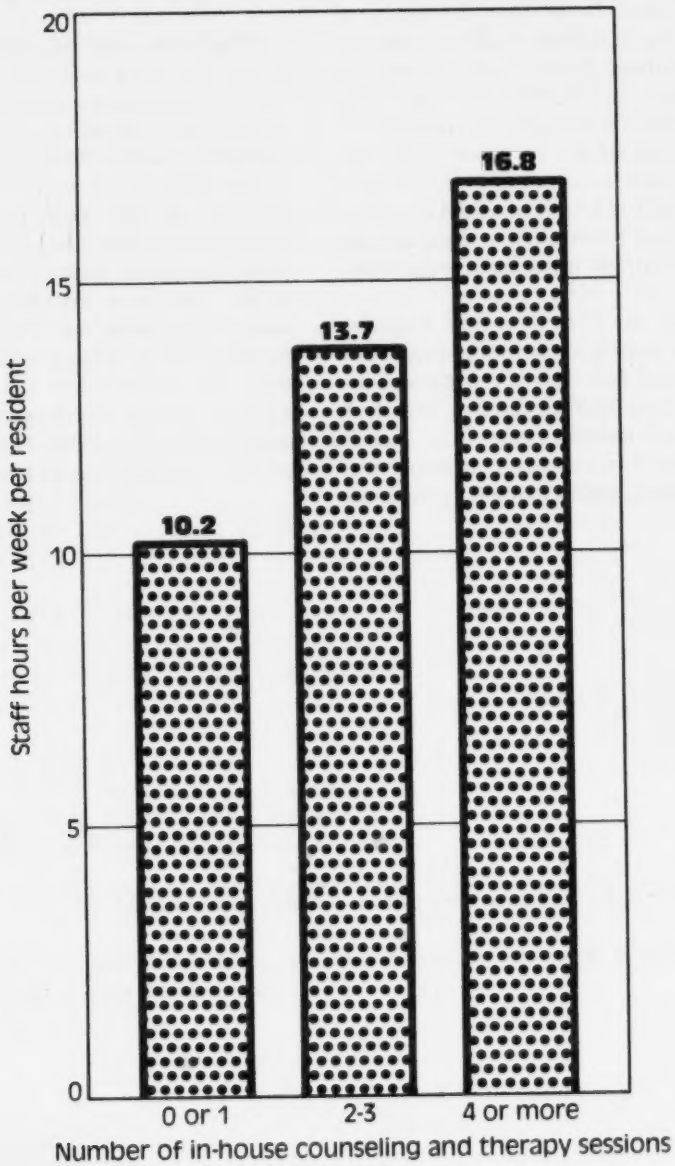
Table 13. Staffing patterns in psychiatric halfway houses and community residences by type of facility: United States, 1976

Staff category[a]	Type of facility							
	All types		Children & adolescents		Adult transitional		Adult non-transitional	
	Number of staff	Average sched. hours per wk.	Number of staff	Average sched. hours per wk	Number of staff	Average sched. hours per wk.	Number of staff	Average sched. hours per wk.
Total staff...	2,282	26.4	244	27.5	1,203	25.4	835	27.5
Full-time...	1,206	41.1	108	45.0	613	40.6	485	40.9
Part-time...	473	14.6	93	17.3	246	13.9	134	13.9
Consultants.	165	4.2	19	2.8	88	3.9	58	5.0
Volunteers..	213	6.1	17	9.5	168	5.8	28	5.8
Trainees & residents.	225	8.3	7	16.4	88	10.5	130	6.4
Number of reporting facilities..	163		19		104		40	

[a]/For definitions of staff categories, see appendix A.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Figure A.
Average number of scheduled staff hours[a] per resident per week by number of in-house counseling and therapy services available in psychiatric halfway houses and community residences: United States, 1976.



[a]Only scheduled staff hours for full-time paid staff during the sample week in February 1976 are included.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences (N=168)

examined further in the sections below on costs and services.

REVENUE SOURCES

Halfway houses and community residences for the mentally disabled draw funds from a variety of sources. Based on information provided by 110 of the 228 (48 percent) halfway houses and community residences identified by NIMH in the 1976 Inventory, receipts from direct services comprise 51 percent of revenue and all but 5 percent of the rest comes from Government sources (table 14). Because less than half the facilities provided useful financial information, we cannot be certain that these data are representative of all halfway houses and community residences.

Total revenue of the 110 reporting facilities included 38 percent from patient fees and about 13 percent from Medicaid; Medicare and programs for the aging did not fund halfway houses. Nearly 8 percent of the total monies came from Social Security Title XX funds, but relatively little use was made of CETA, housing, and CHAMPUS programs. However, "other" local government funds accounted for 11 percent of total revenues, and some of these monies may in fact have come to these facilities from Federal programs *through* local governments.

FUNDING PATTERNS BY FACILITY TYPE

Clearly, the array of funding sources for halfway houses has been so diverse and variable over time that any generalization about funding patterns must be cautiously advanced. To develop a more detailed picture of revenue flows for programs participating in the 1976 inventory, we have examined funding patterns for the three major classifications: (1) children and adolescent programs, (2) adult transitional programs, and (3) adult nontransitional programs. The three leading dollar sources for each facility type have been abstracted from table X in appendix B and are presented in table 15. The data show that resident fees comprise 52 percent of the total income for adult nontransitional programs, 36 percent for adult transitional residences, and only 12 percent for children and adolescent programs.

Table 14. Sources of revenue for psychiatric halfway houses and community residences: United States, 1976[a]

Revenue source	Dollar revenues	Percent distribution
Total receipts from all sources.....	$16,377,688	100.0%
Receipts from direct services.....	8,327,881	50.9
Resident fees.....	6,216,924	38.0
Medicaid.....	2,097,755	12.8
CHAMPUS.....	12,922	0.1
Insurance (Private & voluntary).....	280	0.0
Government funds, total.....	7,174,743	43.8
Federal Government funds, total.....	214,420	1.3
State government funds, total.....	5,045,576	30.8
Social services (Title XX).....	1,220,804	7.5
Vocational rehabilitation.....	481,642	2.9
Other State government funds.....	3,343,130	20.4
Local government funds, total.....	1,914,747	11.7
Labor and manpower programs (CETA)..	49,033	0.3
Housing and community development programs (HUD).....	37,000	0.2
Other local government funds.....	1,828,714	11.2
Donations (Including free contributions from individuals, corporations, charitable organizations, united community chests, and others).....	496,039	3.0
Other fund revenue (Including gains on sales of assets, own fund raising activities, interest earned, and other miscellaneous income).	379,025	2.3

[a] Based on 110 facilities which reported income by source.

Source: 1976 NIMH Inventory of Psychiatric Halfway Houses and Community Residences.

Table 15. Leading sources of revenue (based on proportion of total revenue) for psychiatric halfway houses and community residences: United States, 1976[a/]

Type of facility	Largest funding source	Second largest funding source	Third largest funding source
All types.....	Resident fees (37.9%)	Other State govt. funds (20.6%)	Medicaid (12.8%)
Adult transitional....	Resident fees (36.4%)	Other State govt. funds (21.2%)	Other local govt. funds (13.1%)
Adult non-transitional....	Resident fees (51.9%)	Medicaid (22.7%)	Other State govt. funds (18.4%)
Children and adolescent.....	Other local govt. funds (25.7%)	Title XX (25.2%)	Other State govt. funds (23.8%)

[a/] For a more detailed presentation of sources of funds by type of facility, see appendix B, table X.

Source: NIMH 1976 Inventory of Psychiatry Halfway Houses and Community Residences.

VI. ADMISSIONS AND ADMISSION REQUIREMENTS

CHANGING PATTERNS OF ADMISSIONS

Use of alternative residential services is steadily growing and parallels the continuing decline in the number of hospital beds reserved for psychiatric inpatients. From 1972 to 1976, the estimated number of psychiatric beds in the United States declined almost 30 percent from 471,800 to 332,127 (U.S. DHEW 1978). Meanwhile, the estimated number of beds in psychiatric halfway houses increased from 7,089 in 1973 to 7,965 in 1976, and the estimated number of admissions to these facilities increased from 6,150 to 8,953.

A significant trend toward admissions originating in the community is evident not only from the substantial increase in community residential facility admissions in recent years, but also from the declining percentage of admissions with prior mental hospital treatment. As shown in figure B, the proportion of total residents with prior hospitalization before entering the reporting halfway houses decreased from 76 percent of admissions in 1973 to 63 percent in 1976, while the proportion of residents who entered without prior psychiatric hospitalization increased from about 8 percent of admissions to over 10 percent.

The increasing proportion of residents admitted to commuity residences without previous hospitalization may signal a trend toward increasing use of these facilities as alternatives to institutional-based care and treatment. Support for this premise is further indicated by the large jump (from 15 percent to 23 percent) in the proportion of previously hospitalized residents admitted to community residences who have spent some period of time in community settings after hospitalization. Unfortunately, the types of clinical indicators needed to further assess this potential trend are not available. Nevertheless, the inference that admission patterns are shifting toward clients entering directly from the community seems warranted by these limited data and is consistent with current treatment practices.

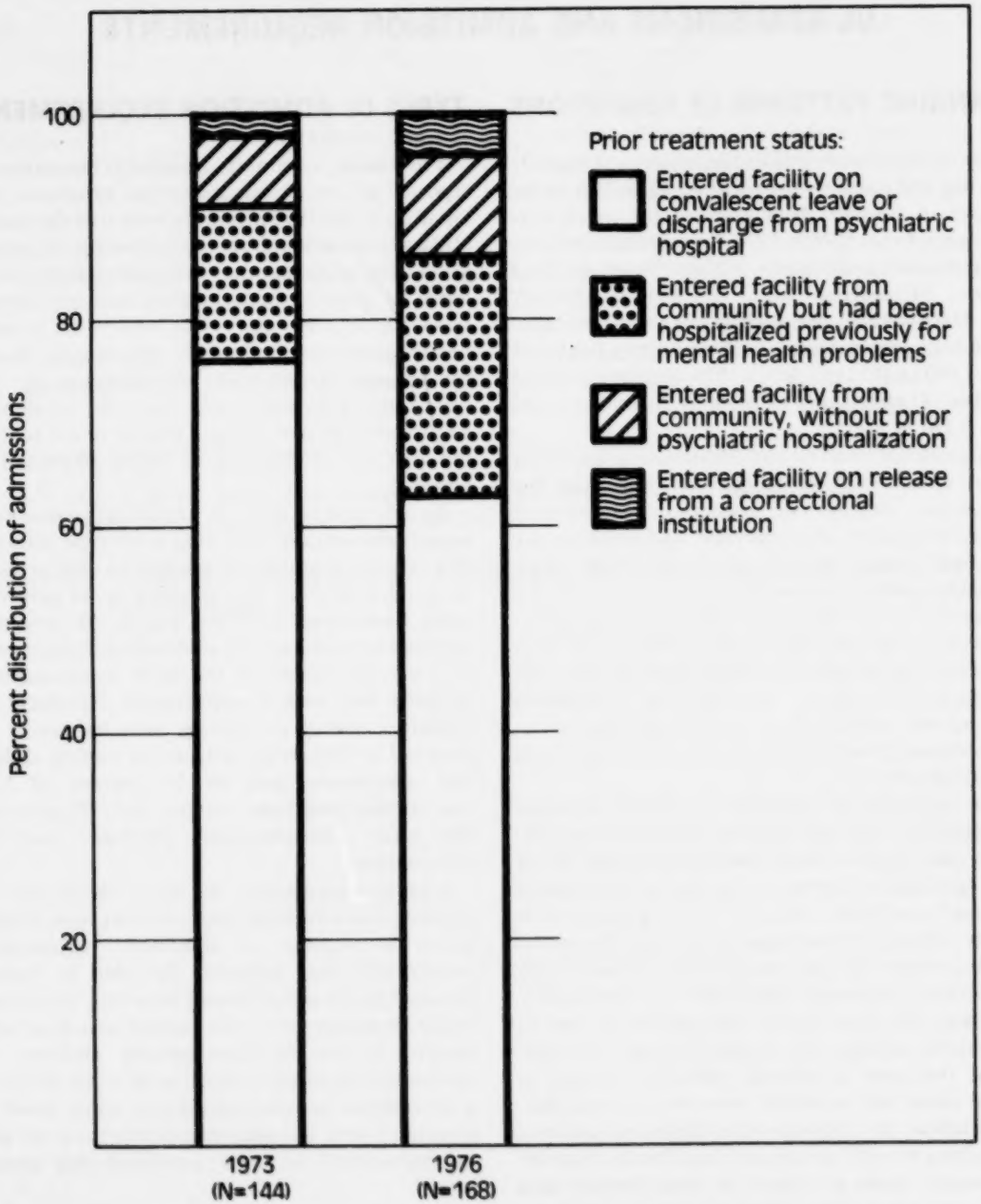
TYPES OF ADMISSION REQUIREMENTS

The most common admission requirements reported by community residential programs participating in the 1976 inventory were that the resident (1) be able to benefit from rehabilitation (75 percent) (2) be able to manage personal needs (70 percent) (3) agree to share in housekeeping and maintenance tasks (66 percent), and (4) be referred by a mental health professional or agency (62 percent). Among the balance of admission requirements, the least frequently indicated were that the resident be employable (23 percent) and that he or she be under the care of psychiatrist or other physician (37 percent).

As indicated in table 16, admission requirements varied substantially according to the type of facility. The requirement that the resident be able to benefit from rehabilitation was reported by 81 percent of adult transitional facilities and by 75 percent of facilities for children and adolescents. Comparatively, only 60 percent of the adult nontransitional facilities had such a requirement. Similarly, the resident's ability to manage personal needs was required by 70 percent of facilities serving children and adolescents and by 73 percent of adult transitional programs, whereas only 62 percent of the adult nontransitional programs had this requirement.

With few exceptions, the adult transitional and children and adolescent facilities were more likely to report a number of admission requirements, particularly that residents be able to manage personal needs and to benefit from rehabilitation. A major departure from this pattern was that only 5 percent of the facilities serving children and adolescents required residents to be under the care of a psychiatrist or other physician, while nearly 40 percent of both the adult transitional and the adult nontransitional facilities stipulated this requirement.

Figure B.
Percent distribution of admissions to psychiatric halfway houses and community residences by prior treatment status: United States, 1973 and 1976.



Source: NIMH 1973 Inventory of Halfway Houses for the Mentally Ill and Alcoholics; NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table 16. Percent of psychiatric halfway houses and community residences reporting specific admission requirements, by type of facility: United States, 1976

Admission requirements	Total[a]	Type of facility: Children and adolescents	Adult transitional	Adult non-transitional
Residents must:				
Be able to benefit from rehabilitation	74.7%	75.0%	80.8%	59.5%
Be able to manage personal needs	69.9	70.0	73.1	61.9
Agree to share in housekeeping & maintenance tasks	66.3	75.0	76.9	35.7
Be referred from mental health professional or agency	61.8	45.0	65.6	61.1
Engage in activity programs within house	60.2	70.0	62.5	50.1
Engage in outside activity	57.8	75.0	64.4	33.3
Be without disabling physical condition	40.4	50.0	39.4	38.1
Be able to pay for services	39.2	25.1	39.4	45.2
Be under care of psychiatrist or other physician	37.3	5.0	43.3	38.1
Be employable	22.9	20.0	30.8	4.8
Other	13.3	30.0	10.6	11.9
Number of facilities reporting	116	20	104	42

[a] A given halfway house or community residence may have more than one admission requirement.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

INTERRELATIONSHIPS OF ADMISSION REQUIREMENTS

Four admission requirements were found to be highly interrelated and to comprise a scale of admissions criteria. Focusing on activity in and around the facility and on vocational rehabilitation, these four items require the resident to (1) be able to engage in in-house activities, (2) be able to engage in outside activities, (3) agree to share in housekeeping and maintenance tasks, and (4) be employable. Using a Guttman scaling program, (1) and (2) above were combined and scored as a simple dummy variable. Appendix C describes the Guttman scaling technique that was used.

The incidence of these selected admission criteria is closely related to the level of services found in the facility as well as to certain resident characteristics. Specifically, facilities with a larger proportion of residents staying over 6 months are significantly less likely to report these admission requirements ($r=.31$, $p < .01$). Conversely, facilities having more admission requirements and expecting a higher level of resident activity are more likely to be licensed and to be licensed specifically as halfway houses rather than boarding houses, intermediate care facilities, or any other type of facility. Further, as discussed below, facilities requiring more resident activity in and around the facility and expecting the resident to be employable are significantly more likely to provide in-house counseling services ($r=.20$, $p<.05$), external counseling services ($r=.25$, $p<.05$), and external facilitative services, i.e., job training and vocational rehabilitation ($r=.25$, $p<.05$). Thus, clusters of services and admission requirements are evident and influence the degree to which the facility is rehabilitation oriented.

VII. RESIDENT SERVICES

OVERVIEW

The halfway house inventory of 1973 asked facilities to report the direct provision of services to their residents. A check indicated the presence or absence of the service without either indicating the number of clients receiving the service or specifying the modality of service in any more definitive terms. Although no detailed descriptions of a service or measures of utilization were recorded, the twelve categories included in the instrument did clearly discriminate among programs. In particular, programs which were transitional (50 percent or fewer of their clients had been in residence for 6 months or longer) were more likely to provide individual or group counseling or therapy, counseling of exresidents, and job placement. Nontransitional facilities were more likely to provide family therapy, planned recreation activities, and religious services.

The listing of services in the 1976 inventory added *medical examination* and *psychiatric evaluation*. These two new items and the splitting of the earlier single counseling/therapy item into two separate items (one for individual counseling or therapy and one for group counseling or therapy) brought the number of services listed to 15. Because it was recognized that many halfway-house programs deliberately limit the provision of in-house services to encourage the client's use of mainstream community services and resources, the 1976 format also asked facilities to report on the use of external agencies to supplement in-house services through formal agreement or contractual arrangement. This modification to the inventory proved valuable and revealed that facilities did in fact depend on external services — particularly on those which community-based programs would have difficulty providing internally. As indicated in table 17, only 6 percent of the facilities reported in-house medical examinations, but 46 percent of the facilities reported that medical examinations were available through outside agencies. Similarly, although fewer than 25 percent of the facilities performed in-house psychiatric examinations, almost 55 percent provided for such examinations through external agencies.

The more common in-house services, provided in about two-thirds of the facilities, include: (1) individual counseling or therapy, (2) group counseling or therapy, (3) planned recreation programs, and (4) house meetings. Also, more than half the programs helped their residents find long-term housing. Typical external services were medical and psychiatric examinations, provided by about half the facilities. External job counseling and vocational training were also used frequently. The most common activity or service was the house meeting (83 percent), an almost exclusively in-house activity.

A more detailed study (including factor analysis) of internal and external services available to halfway-house residents by type of facility is presented in appendix D.

LEVEL OF IN-HOUSE COUNSELING SERVICES BY ADMISSION REQUIREMENTS AND BY LENGTH OF STAY

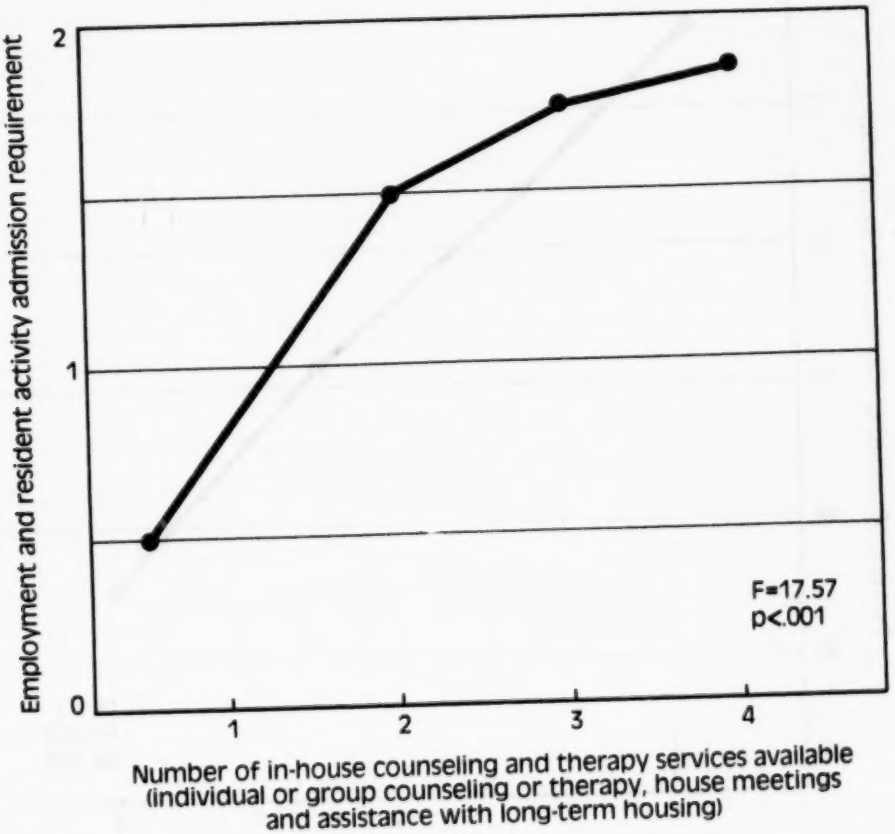
Appendix C and the previous section on admission requirements have shown that the resident's ability to engage in internal or external activities and his or her ability to become employed form an internally consistent Guttman scale. This scale of admission requirements showed that the higher the score for required resident activities and capabilities, the higher the level of in-house counseling or therapy services. As indicated in figure C, a strong, positive relationship exists between requirement for admission and the level of internally provided counseling services ($F=17.57$, $p.< .001$). Thus, clients who are expected to be more active are more likely to be in programs which provide more extensive counseling services. Adult transitional facilities, as already noted, are more likely to have these requirements.

Table 17. Proportion of psychiatric halfway houses and community residences providing specific services in-house or by contractual agreement with external agencies: United States, 1976

Type of service	Provided in-house	Provided externally
House meetings	83%	2%
Planned recreation activity program	67	14
Group counseling or therapy	67	25
Individual counseling or therapy	67	30
Assistance in finding long-term housing	64	14
Counseling ex-residents	54	19
Vocational rehabilitation & employment counseling	43	44
Job placement	43	36
Family therapy	34	17
Educational program	19	36
Religious services	13	24
Medical examination	6	46
Alcoholics anonymous services	2	16
Detoxification services	-	12
Number of facilities reporting	166	

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

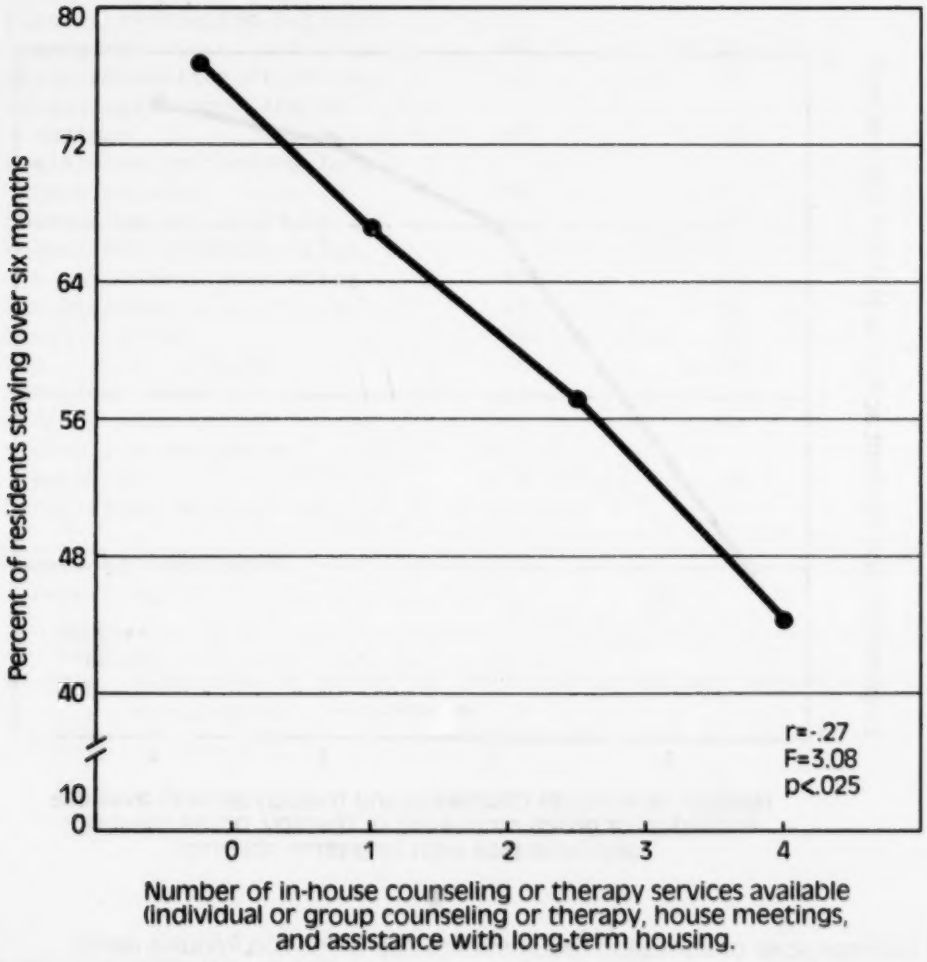
Figure C.
Relationship between number of in-house counseling and therapy services available in psychiatric halfway houses and community residences and the level of client admission requirements relating to employment potential and resident activity: United States, 1976[a].



[a] A Guttman scale of admission requirements (See Admission Requirements, Appendix C) was constructed from four items requiring employability or resident activity in or outside the facility.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Figure D.
Proportion of residents staying over 6 months by number of in-house counseling or therapy services available: United States, 1976.



Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Continuing this analysis, figure D graphs the relationship between the percentage of clients in residence for over 6 months and the level of in-house counseling services. Clearly, facilities with higher proportions of long-term clients report lower levels of internal counseling or therapy services.

VIII. ECONOMICS OF RESIDENTIAL CARE

This section presents a review of program cost analysis, particularly the relationships between cost, services, and staffing. In addition, a statistical model developed earlier has been replicated with more recent data (Piasecki and Pittinger 1977). The results of this replication are also considered in this section.

Per diem costs (total annual expenditures divided by the number of client care days for the year) were found to vary with the level of services provided by or through residential facilities — but not uniformly. For adult transitional programs, the higher the level of in-house counseling services, the higher the per diem cost. Facilities offering three of four of these services reported average per diem costs of $15 to $19; those providing fewer of these services averaged per diem costs from $11 to $13. The greater the use of external counseling services, the *lower* the average per diem. Use of external services may not reduce rehabilitation costs, however, because the *total* cost for client services may remain stable or even increase as more expenditures accrue to other facilities. Adult transitional facilities make greater use of such services, so the overall cost of rehabilitation efforts for their clientele cannot be adequately determined from data provided by residential facilities, which do not reflect the costs incurred by external agencies participating in the rehabilitation effort.

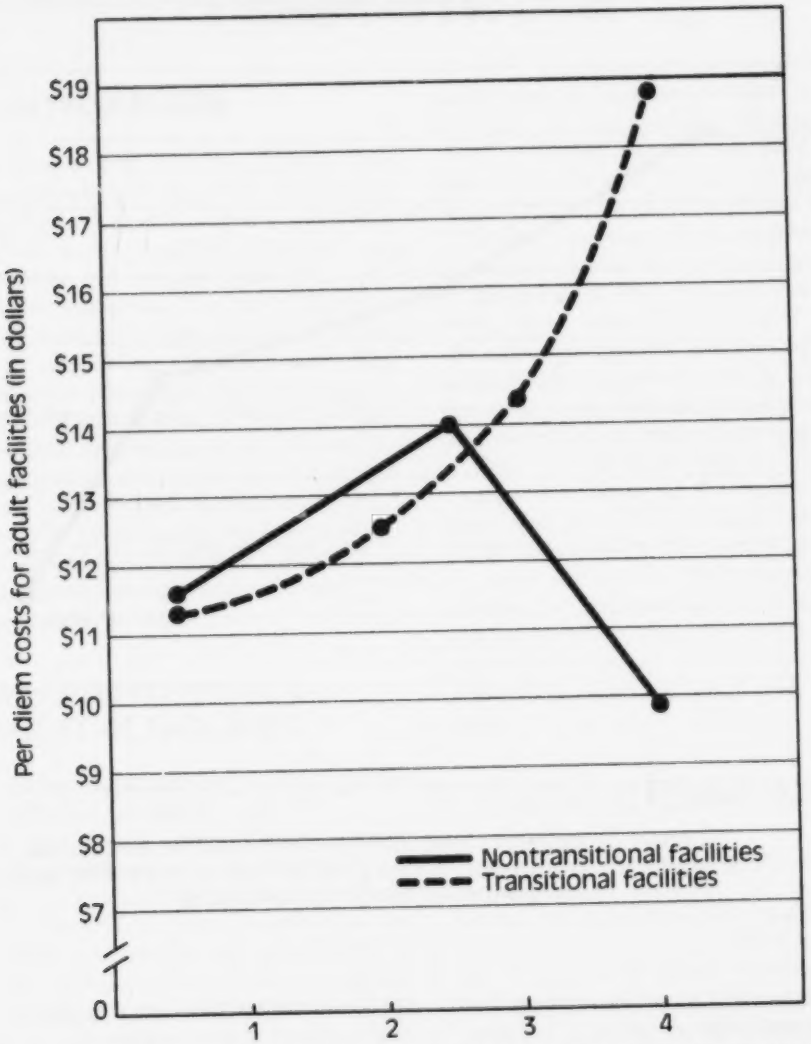
For adult nontransitional programs, on the other hand, there is no clear relationship between cost and level of in-house services. As figure E demonstrates, average per diem costs for these programs range from about $13.50 to $19.50, with high-service facilities and low-service facilities reporting similar cost levels.

If the site-of-service factor is significant in residential economics, we would expect a negative relationship between other external services and costs. The results presented in figure F bear out this expectation: They show a strong negative relationship between per diem cost and the use of external facilitative services (job placement, vocational training, educational programs). The greater the use of these externally provided services, the lower the cost of adult facilities.

Thus, the more the facility invests in on-site client adjustment services, the more it spends per client. This occurs as a result of the greater use of a part-time or full-time professional staff, particularly clinicians. The site substitution effect, which lowers the direct cost for residential programs to the extent that rehabilitative and therapeutic services are provided externally by other agencies or units, is observed only for transitional programs, which as a group have more total services. However, the cost reduction resulting from substitution is not sufficient to reduce costs of transitional programs below the levels reported for nontransitional facilities. The process appears to place a ceiling on direct costs rather than to lower them.

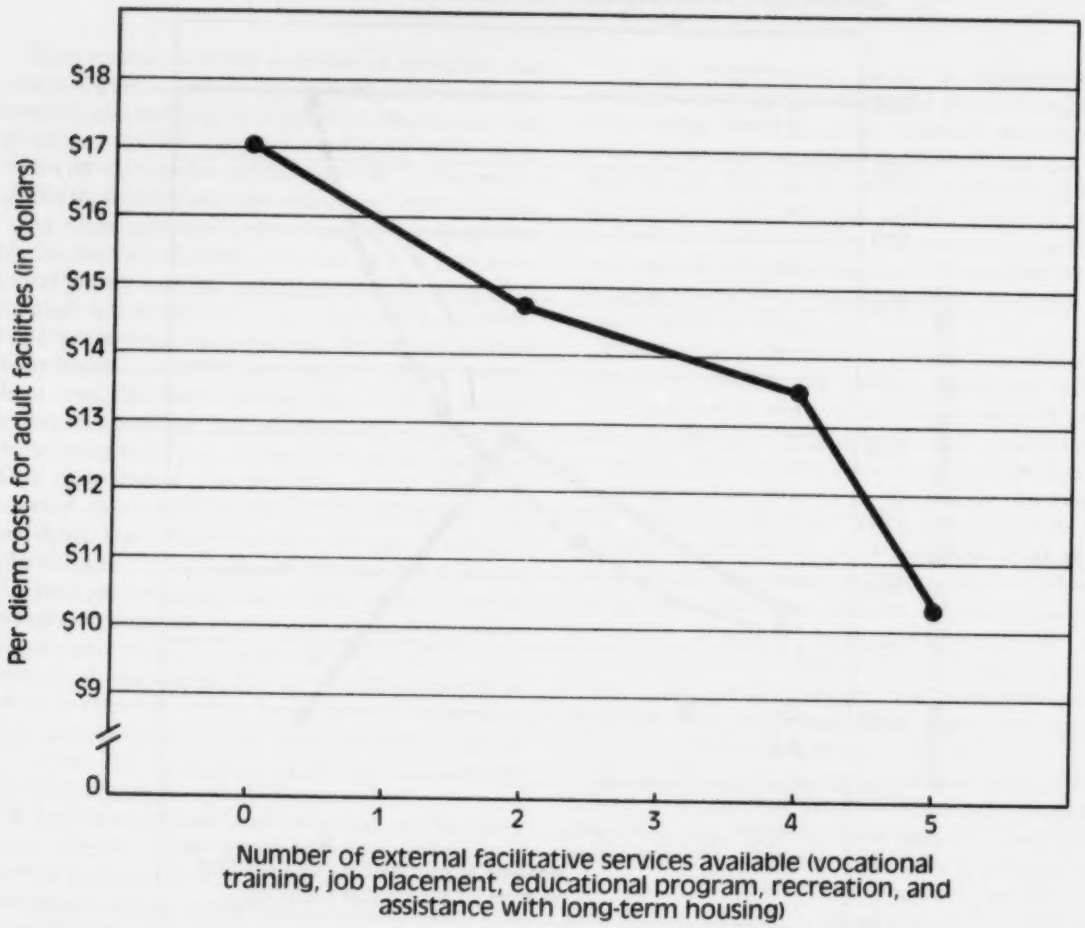
Although these displays are useful in highlighting certain relationships between costs and program characteristics, a more inclusive model for predicting costs may be considered. Appendix E presents the results of such a multivariate approach, which takes cost as the dependent variable and a number of facility characteristics and program measures as independent variables in a multiple regression.

Figure E.
Per diem costs in transitional and nontransitional psychiatric halfway houses and community residences by number of in-house counseling and therapy services available: United States, 1976.



Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Figure F.
Per diem costs in psychiatric halfway houses and community residences by number of external facilitative services available: United States, 1976.



Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

IX. TRENDS IN SERVICES AND ADMISSIONS FOR A COHORT OF FACILITIES

INTRODUCTION

Of the 228 respondents to the NIMH 1976 inventory, 124 also participated in 1973. Of these, 77 provided relatively complete reports on both inventories. That is, respondents completed the "long form" mailed instruments rather than only the shorter telephone inquiry. Thus, for a sample of 77 facilities, a cohort of respondents provided information on admissions, services, and other aspects of residential programs. The advantage of cohort analysis over cross-sectional samples is that change (or stability) over time can be observed for the same reporting units. For example, the increase in total admissions to residential facilities since 1973 does not necessarily mean that individual facilities have experienced increases. With data from the same cohort of programs reporting over time, individual facility changes can be noted.

SERVICE PATTERNS IN A COHORT OF FACILITIES

The three services most frequently offered by the cohort of residential programs (table 18) were individual or group counseling/therapy, house meetings, and planned recreational programs — a pattern similar to other noncohort programs. Table 18 indicates the status of each type of service for the cohort respondents for both 1973 and 1976. Of the 77 facilities, 66 (54 + 12) provided individual or group counseling/therapy services in 1973. Three facilities added services in this category, while 12 which had reported these services in 1973 did not report them for 1976.

Service patterns show considerable variability over the fairly short 3-year span between inventories. About 20 percent of the facilities which initially (1973) reported client counseling and therapy dropped these services, and 50 percent of the programs which provided family therapy (9 of 18) discontinued this service. However, nine facilities added family therapy, so the total number of facilities in the cohort offering such services remained stable. As data from 1976 indicate, family therapy is provided by external agencies almost as frequently as it is provided in-house.

Table 18 also shows that a number of the facilities providing job placement, educational, and vocational programs in 1973 discontinued these efforts. In 1976, these same services were often provided through referrals to outside agencies. External agencies play important roles in supplementing in-house services, including vocational, educational, and individual or group counseling/therapy services.

The core of three services provided in 1973 continued to make up the basic service package at these sites in 1976. The first two, recreation and house meetings, involve the resident in participative activities centered on interpersonal exchanges that enhance or maintain self-assurance and relationships with others. The third, more clinical, service of individual or group counseling/therapy is usually available to assist the resident undergoing rehabilitation.

CLIENT TREATMENT BACKGROUND

As discussed earlier in Admissions and Admission Requirements, there is an apparent shift in admissions to residential facilities with respect to the client's previous hospitalization. A review of data for the 77 cohort programs disclosed that for those facilities responding in both years, total admissions increased at about the same rate as they did for all facilities inventoried, from 2,139 in 1973 to 3,141 in 1976 (table 19). Further, the proportion of persons entering the cohort facilities directly on leave or discharge from hospitals declined from 78 percent to about 67 percent over the 3 years, while the proportion decreased from 76 percent to 63 percent for all reporting facilities over the same period (see figure B). The number of clients who entered the facility from the community without prior psychia-

Table 18. Provision of specific services over time by a cohort of psychiatric halfway houses and community residences: United States, 1973 and 1976

Type of service	In-house services provided				External services
	In 1973 & 1976	In 1973 only	In 1976 only	In neither year	Provided in 1976
House meetings.....	60	9	3	5	-
Individual or group counseling/therapy.....	54	12	3	8	28
Planned recreation activity program.....	35	18	10	14	11
Counseling ex-residents...	28	17	16	16	13
Job placement.....	24	20	7	26	24
Vocational training.....	10	8	22	37	34
Family therapy.....	9	9	9	50	14
Educational program.....	7	11	4	55	24
Religious services.....	5	1	1	70	19
Number of facilities reporting completing "long" form both in 1973 and 1976.....			77		

Source: NIMH 1973 Inventory of Halfway Houses for the mentally ill and alcoholics and NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table 19. Number and percent distribution of admissions to psychiatric halfway houses and community residences by prior treatment category for a cohort of facilities: United States, 1973 and 1976

Prior treatment category	Admissions in 1973		Admissions in 1976	
	Number	Percent	Number	Percent
Total.....	2,139	100.0%	3,141	100.0%
Entered facility on convalescent leave or discharge from psychiatric hospital.	1,669	78.0	2,099	66.9
Entered facility from community, without prior psychiatric hospitalization.....	106	5.0	651	20.7
Entered facility from community, but had been hospitalized previously for mental health problems....	343	16.0	334	10.6
Entered facility on release from a correctional institution.....	21	1.0	57	1.8

Source: NIMH 1973 Inventory of Halfway Houses for the mentally ill and alcoholics and NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

tric hospitalization, increased significantly for the 77 cohort programs, from about 5 percent to over 20 percent; such admissions increased only from 8 percent in 1973 to 10 percent in 1976 for all reporting facilities.

Thus, the cohort of facilities showed greater increase in the rate of accepting residents who had never been hospitalized. Although the cohort comprised fewer than one-half of all facilities reporting in 1976, data from both the cohort and from newly reporting facilities reveal a trend toward greater use of community services by more residents referred directly from the community.

ADMISSION REQUIREMENTS FOR A COHORT OF FACILITIES

Table 20 presents changes in admission requirements reported by a cohort of facilities from 1973 to 1976. For the cohort as a whole, the three most frequently applied admission criteria were (1) be able to manage personal needs (N=54), (2) agree to share housekeeping and maintenance tasks (N=53), and (3) be able to benefit from rehabilitation (N=50).

New admission requirements were reported by a number of facilities. The most common (N=16) was that the applicant be without a disabling physical condition. The second most frequently occurring new requirement (N=14) was that the resident be able to pay for services. Note that admission requirements tended to lessen between 1973 and 1976, insofar as there were more deletions than there were new requirements.

The least common requirements were that the resident (1) be employable (N=21), (2) be able to pay for services (N=31), (3) be under the care of a psychiatrist or other physician (N=32), and (4) be without disabling physical condition (N=33).

The most frequently discontinued items were that the resident (1) be able to manage personal needs, (2) be able to benefit from rehabilitation, (3) engage in activity programs within the house, and (4) be under the care of a psychiatrist or other physician.

In review, a trend toward increased admissions per facility has emerged concurrent with some reduction in available services and a relaxation of admission requirements. The pattern of change — particularly the lessening of requirements that the client exhibit "rehabilitation potential" — suggests that residential facilities may be setting more modest goals. Also significant is an increased focus on clients with limited or no prior experience in mental institutions.

Table 20. Number of psychiatric halfway houses and community residences responding in 1973 and 1976 by change and stability of admission requirements[a/]: United States, 1973 and 1976

Admission requirements	Facilities reporting	Facilities with current (1976) requirement		Facilities without current (1976) requirement	
		Required in 1973	Required since 1973	Not required in 1973	Deleted since 1973
Be able to manage personal needs.	77	47	7	19	4
Agree to share housekeeping & maintenance tasks.....	77	49	4	10	14
Be able to benefit from rehabilitation.....	77	44	6	16	11
Referred by mental health professional or agency.....	68	41	5	11	11
Engage in outside activity.....	77	34	11	14	18
Engage in activity programs within house.....	77	31	10	21	15
Be without disabling physical condition.....	77	17	16	14	30
Be under the care of a psychiatrist or other physician.....	77	25	7	17	28
Be able to pay for services.....	77	17	14	12	34

[a/] Additional requirements included in the 1973 Inventory, which referred primarily to alcohol programs were not included in the 1976 Inventory and are not shown here.

Source: NIMH 1973 Inventory of Halfway Houses for the Mentally Ill and Alcoholics and the NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

X. METHODOLOGICAL NOTES

A. FACTORS RELATED TO INCLUSION OR NONINCLUSION IN THIS INVENTORY

Survey Format

The NIMH used both mailed instruments and telephone surveys to obtain data for the 1973 and the 1976 inventories. For each inventory, the majority of responses were collected through the mailed instrument, a detailed, four-page questionnaire (see appendix A for the 1976 instrument). To improve the response rate, those facilities who had not filled out the questionnaire were contacted by telephone and questioned on 15 items selected from the mailed instruments.

Data items sought by both survey methods in 1973 included name and location of the facility, type of ownership and control, number of years in operation, policies regarding admission, length of stay, number of employees by staff discipline, number of beds, and number of residents. In addition, the mailed questionnaire asked about annual expenditures, resident charges, residents' means for paying halfway-house expenses, and sources of halfway house support. In 1976, both versions included questions on type of control and ownership, age and type of residents served, occupancy and capacity of the facility, total annual admissions, licensing requirements, and type of monthly resident charges. The mailed instrument added admission requirements, number of staff and hours worked, services provided in-house and by agreement with an outside agency, prior treatment history, and source of support for the halfway-house program.

Response Patterns of the 1973 and 1976 NIMH Inventories

In 1973 a total of 209 facilities serving the mentally ill responded to the inventory; 65 of these were contacted by phone, and 144 responded by mail. The sample of 228 facilities responding to the 1976 inventory included 121 (25 by phone; 96 by mail) who had participated in the 1973 inventory (table 21). These are considered to be continuing programs; the other 107 respondents in 1976 were first-time participants.

When cross-tabulating type of response (telephone inquiry or mail version) by year of inventory (1973 or 1976), we note that nonresponse to the 1976 inventory is considerably higher for those programs participating in the 1973 telephone inquiry (51 percent) than for those completing the mail instrument (38 percent) in 1973 (table 21). Second, those facilities originally (1973) responding to the *mail* instrument were more likely to provide a mailed response in 1976: 58 percent repeated their participation by mail. Significantly, one-third of the *telephone* participants in 1973 changed to response by mail in the 1976 inventory, perhaps indicating continuity of participation over time.

To summarize, the dropout rate is likely to be higher for facilities responding only by telephone than for those responding with completed questionnaires. However, a relatively high proportion of telephone respondents will continue to participate, and even to provide a mailed response, in a later effort. Also, once a mailed response is obtained, continued participation over time is more likely. It would seem reasonable to project that given the identical sample of 121 cases for a third and future effort, the proportion of telephone responses made necessary would be very small, implying a much lower dropout rate and a higher number of cases reporting, as well as more inclusive reporting of data.

Disposition of Cases Surveyed in 1973 and Excluded in 1976

As table 22 shows, 88 of the 209 psychiatric facilities included in the 1973 inventory did not respond to the 1976 inventory. Eighteen terminations were reported and confirmed by NIMH personnel. In addition, 51 of the facilities responding in 1973 were determined to be no longer "in-scope" with the inventory's new focus which concentrated on freestanding as opposed to subsidiary facilities.

Table 21. Reasons characteristics for a cohort of psychiatric halfway houses inventoried in 1973: United States, 1973 and 1976

Type of response in 1976	Type of response in 1973		
	Total	Telephone inquiry	Mailed instrument
	Number of halfway houses		
Total.....	209	65	144
Phone inquiry..	25	12	13
Mailed response	96	20	76
Nonresponse....	88	33	55
	Percent distribution of cohort in 1976 according to type of response in 1973		
Total.....	100.0%	100.0%	100.0%
Phone inquiry..	12.0	18.0	9.0
Mailed response	45.9	31.0	53.0
Nonresponse....	42.1	51.0	38.0
	Percent distribution of cohort in 1973 according to type of response in 1976		
Total.....	100.0%	31.1	68.9
Phone inquiry..	100.0%	48.0	52.0
Mailed response	100.0%	20.8	79.2
Nonresponse....	100.0%	37.5	62.5

Chi-square = 10.49 d.f. = 2 p<.01

Source: NIMH 1973 Inventory of Halfway Houses for the mentally ill and alcoholics and NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences

Table 22. Reasons for nonresponse of 88 psychiatric halfway houses responding in 1973 and not responding in 1976: United States, 1973 and 1976

Reason for nonresponse, 1976	Halfway houses	
	Number	Percent
Total respondents 1973 & nonrespondents 1976.....	88	100.0%
Out-of-business: (total).....	18	20.5
Out-of-scope: (total).....	51	58.0
Program coterminous with CMHC.....	15	17.0
Vocational rehabilitation emphasis.	12	13.6
Serves other client groups.....	11	12.5
Other type of residential program..	7	8.0
Coterminous with other program.....	6	6.8
Other[a/]	9	21.5

[a/] No forms are available for these cases which may include both out-of-business and out-of-scope programs.

Source: NIMH 1973 Inventory of Halfway Houses for the mentally ill and alcoholics; follow-up in 1976 with exclusion from current inventory.

Twelve facilities that reported a vocational rehabilitation emphasis were deleted, and another 18 of the 51 out-of-scope cases were excluded because they served primary client groups other than the mentally ill or because their residential programs did not conform to the program definitions employed for the survey. Further, as in 1973, NIMH researchers sought to eliminate coterminous facilities from the data set; that is, facilities which accepted patients or clients only from a parent organization. This later criterion eliminated 15 of the facilities in the 1976 data which reported themselves to be coterminous with community mental health centers (CMHCs) while another 6 were found to be coterminous with other programs.

Since the 1976 inventory of community-based halfway houses and long-term residential living programs for the mentally disabled specifically focused on freestanding facilities, those which were found to be coterminous with a larger mental health program or agency were excluded. For example, programs identified as coterminous with a parent organization and surveyed through other NIMH inventories (including the CMHC inventory, the inventory of State and county mental hospitals, and the inventory of other psychiatric facilities) were formally deleted from the 1976 sample. Data taken from the psychiatric facilities inventory and the inventory of State and county mental hospitals show that at least 61 halfway-house programs (table 23) are operated in conjunction with these other psychiatric facilities. Of the 61 halfway-house programs reported, 29 were adjuncts to psychiatric hospitals, 22 were associated with residential treatment centers (children's facilities), and the remaining 10 were affiliated with outpatient clinics, nonfederally funded mental health centers, and general hospitals.

Nineteen of the 1973 programs never responded; it may be presumed that most of these programs either were terminated or refused to participate. Thus, adding the 18 facilities that reported themselves out of business to the 19 nonresponses (which might be out-of-business facilities), the rate of discontinuance for halfway-house programs from 1973 to 1976 ranges from 6 to 12 programs per year — a relatively low rate of program closure. Several insights on program termination and confirmation of the relatively low failure rate are provided in the section below, which discusses the followup survey of newly reporting facilities.

In conclusion, the shifting focus of the NIMH inventory of halfway houses and long-term community residential programs has added over 100 facilities to the inventory roll, while as many as 100 may have been excluded. About one-half of the newly reporting facilities have opened since 1973. However, the inclusion of new facilities specializing in the provision of long-term care and the exclusion of previously reporting programs found to be coterminous (many of them emphasizing vocational rehabilitation) or out of business has substantially changed the character of the data set. Thus, general comparisons between facilities reporting in 1973 and those reporting in 1976 may be misleading. For this reason, and given the strength of the cohort approach, matched items on services and admissions for a set of facilities reporting in both years were provided and reviewed in IX, "Trends in Services and Admissions for a Cohort of Facilities."

B. A FOLLOWUP OF NEWLY RESPONDING FACILITIES

Introduction

Of the 228 facilities responding to the 1976 inventory, 105 were first-time participants. Since the 1976 version of the inventory did not request the facility's start-up date, the assumption that these newly responding facilities were in fact "new" became questionable. It was therefore decided to resurvey these cases to learn if they had been overlooked or had chosen not to participate in an earlier inventory. In December 1977, Horizon House Institute sent a letter to these 105 facilities asking them to participate in a brief telephone inquiry.

Recontacting these facilities provided an opportunity to add and update several items of basic concern to those who operate and plan residential facilities. These questions (administered by phone) included the opening date, activities during the planning period, and initial community reaction. Because most of the facilities would be new, their reports about neighborhood acceptance or opposition would supplement and update earlier studies of community reaction (Piasecki 1975).

Survey Procedures

Pre-addressed, postage-paid postcards were enclosed with a letter asking facility directors when they could conveniently be contacted. Directors were offered the choice of six designated call days and a preference for morning or afternoon calls. Thirty-one postcards, or approximately 30 percent of the original 105 sent out, were mailed back; 28 were

Table 23. Number and percent distribution of coterminous[a] halfway house programs (facilities not included in 1976 NIMH inventory of halfway houses): United States, 1976

Coterminous Mental Health Facility	Number of halfway house programs	Percent
All facility types.....	61	100.0%
Psychiatric hospitals.....	29	47.5
State and county.....	16	26.2
Veterans administration.....	3	4.9
Private.....	7	11.5
Veterans administration General hospitals.....	3	4.9
Residential treatment centers....	22	36.1
Outpatient clinics.....	5	8.2
Non-federally funded mental health centers.....	4	6.6
General hospitals.....	1	1.6

[a] Halfway house programs whose total client population was also enrolled in other psychiatric programs. These facilities were not surveyed directly by means of the 1976 halfway house inventory.

Source: NIMH Inventories of Mental Health Facilities and General Hospital Psychiatric Services (excluding federally assisted CMHCs).

marked with specific dates and time to call. Interviews for these facilities, including the three that had either initially refused to participate or had failed to specify a date, were then completed.

Telephone contacts with the 74 facilities that had not sent back postcards resulted in 64 additional interviews. Although we did not expect the resurvey effort to disclose programs that had terminated since 1976 (the resurvey was done in the winter of 1977), 8 of the 10 cases for which data were not obtained were confirmed as having gone out of business. Thus, only 2 of the 105 cases were not interviewed.

Specifically, the telephone survey sought information in six areas: (1) beginning year of operation, (2) the planning period prior to serving residents, (3) auspice, (4) opposition, either current or before opening, (5) plans for additional sites, and (6) regulation by governmental authority. Several of the questions were difficult to administer. Items calling for recollection of detail (e.g., dates, time periods, and expenditures from past time periods) elicited less complete answers due to poor recall, personnel changes, or program modifications. Key terms in the questionnaire—including "planning," "auspice," or "opposition"—often had to be defined and elaborated. Completing an interview generally required two or three phone calls. Respondents who had specified a time for the interview in advance were better prepared for the questions. Telephone interviews, therefore, were efficient and yielded a high rate of return when the population had previously participated in similar survey efforts.

Attrition in the Ranks: Program Terminations

The reported causes for termination provided an informative sample of reasons for closure. Six of the eight who closed their doors did so because of one or more of the following items: lack of funds, staffing problems, insufficient clientele, or an 'economically infeasible' situation. One facility, which had originally operated a residential program for juveniles, had shifted its focus to outpatient counseling services for high school students and their families. Thus, the program was not forced out of the residential market—it merely changed its modality of service. Several of the terminated programs, however, were compelled by various circumstances to close their residential facilities. A for-profit residential care home in Santa Monica, California reported that continued operation would be "...economically infeasible." Several facilities in Minnesota and Wisconsin reported that a lack of demand for their services was responsible for their closure, adding that there was a low demand for residential services in their areas.

Another program, sponsored by a church-based organization in an eastern State, closed its program after receiving ". . . only grossly inappropriate referrals from a public child welfare agency funding the program. Although the program was established to serve young women who had only minimal impairments, it was reported that persons referred to the facility were "... candidates for hospitals." Three other programs closed residential facilities because of lack of staff, inadequate funding, or both. No program indicated that community opposition was directly or indirectly responsible for termination of residential service.

New Versus Newly Reporting: Under-Enumeration of Residential Facilities

Although 57 percent of newly reporting facilities had opened since 1972, 40 facilities new to the 1976 inventory had started serving residents prior to 1973 but had not been included in the 1973 inventory. Some of these facilities provide long-term residential services and thus would not have qualified for inclusion in the 1973 inventory of "halfway houses." However, most of the newly responding facilities did meet the requirements for "transitional rehabilitative supervised residential programs" that were the defining characteristics of halfway houses in both the 1973 and 1976 inventories.

The goal of the NIMH inventory of halfway houses and community residences was to survey the whole population, but realities dictated that only a sample could be surveyed, and under-enumeration of community residence programs was inevitable. Unlike the large, publicly supported mental health and health institutions (e.g., mental hospitals and federally funded CMHCs), community-based residences are often operated by individuals, subsidized by private donations, and staffed with paraprofessionals and volunteers. The many intersecting and parallel networks of accrediting bodies, professional affiliations, public licensure procedures, and public funding do not always, or even often, include community-based residences for the mentally ill.

C. TOWARD A TYPOLOGY FOR COMMUNITY-BASED RESIDENTIAL FACILITIES

The rapid expansion of community-based residential mental health programs over the past decade

has not been limited to halfway houses. As rapid deinstitutionalization produced new requirements for community living programs, discharges soon outran the ability of state and local mental health systems to mount massive and appropriately staffed halfway-house-type programs. At the same time, there was recognition that a halfway house may not be appropriate for every client. Therefore, until various types of psychiatric rehabilitation services became more clearly focused, the NIMH inventory of halfway houses lagged behind the rapid change in programs and client populations.

When started in 1969, the NIMH inventory focused primarily on halfway houses. By 1976, the inventory had been twice revised to include long-term, nontransitional residential programs for the mentally disabled as well as for halfway houses. Programs other than transitional facilities have become increasingly important in many communities, and far more clients are being cared for in long-term residences for the mentally disabled than in halfway houses.

In several States and numerous major cities, planned and unplanned long-term community residential programs have proliferated in an often rapid, inadequately licensed, and poorly supervised expansion of proprietary facilities for the deinstitutionalized mentally ill. In California, for example, three basic types of community-based shelter and care facilities have been identified: family care homes, halfway houses, and board-and-care homes.

> In California there are approximately 1,155 facilities in the state serving non-retarded individuals between 18 and 65 years old who have had some experience in a psychiatric inpatient facility. Family care homes account for 26% of the facilities in California and serve 14% of residents in sheltered care. Halfway houses, which have by far received the greatest attention from mental health professionals, constitute only 2% of the facilities and serve only 3% of the population in sheltered care. Board-and-care homes, which have developed in an unplanned, *ad hoc* manner, service 82% of the California sheltered care population and comprise 72% of the state's facilities . . . an entirely new residential care system for the mentally ill is emerging. The more familiar and well defined facilities—halfway houses and family care homes—have only a minor role in this new system (Segal and Aviram 1978).

As new formats have developed, a continuum of community-based residential programs offering *varying levels of care and supervision* has become a significant factor in the growth of community mental health services. Many of these community-based residential programs, however, provide only minimal rehabilitative or supportive services. In the case of certain large nontransitional facilities, often licensed and operated as nursing homes, community "mini-institutions" may have emerged.

An unanticipated but important result of presenting the data from the NIMH 1976 inventory has been an effort to provide a clearer categorization of the actual conditions under which the mentally ill live in community residences by discriminating among the various types of facilities reporting. In an earlier study, a taxonomy of facilities was developed that classified facilities by the extent of care or rehabilitation services they provided. This classification proceeded from the recognition that:

> there is no agreed-upon set of definitions that categorizes the wide range of residential facilities in the psychosocial rehabilitation field. Intake criteria, target population served, length of stay, treatment objectives, services offered, staffing patterns, costs, and other factors tend to be so diverse that a unified classification is difficult to formulate (Piasecki and Pittinger 1977).

Providers complicated the problem of developing a classification framework by indiscriminately using different terms to describe similar facilities. Such designations as "boarding home," "board-and-care facility," "group home," "hostel," or "domiciliary care facility," did not provide meaningful or shared references for the various agencies and individuals using them and tended to be used somewhat interchangeably by different authorities.

In analyzing the NIMH 1976 inventory data, alternative arrays of facility attributes were reviewed. It was found that community-based mental health-oriented residential programs could be readily differentiated into three categories: children and youth facilities, transitional rehabilitative facilities, and long-term care residences. Facilities that serve juveniles are quite different in many respects from facilities that serve adults. Overall, facilities for children have a higher staff/client ratio, employ more professionals, limit the number of residents, provide more costly services, and maintain both sex and age segregation (fewer than 20 percent of adult facilities serve only one sex, but 64 percent of facilities for juveniles do so).

The major bifurcation for classification of adult programs is between transitional and nontransitional focus, the same major categories that were used in the NIMH 1973 inventory (NIMH 1975). Facilities that serve as a transition between hospital and community living or as a relatively short-term residential arrangement for clients who are expected

to return fairly rapidly to more independent community living were classified (and often licensed) as halfway houses. It is this type of transitional facility which the 1969 inventory was initially designed to study, for it was anticipated that growing numbers of new residences would join the already increasing ranks of transitional programs.

The nontransitional or relatively long-term residential program, grown prevalent in recent years, has become the place of residence for many thousands of seriously mentally disabled persons. This second major category of facilities includes single room occupancy hotels (SRO's) as well as small adult foster care programs, apartment cooperatives, and other small-to-moderate size residential facilities providing supportive services and 24-hour supervision. Many of these facilities, including those termed board-and-care programs, have their origins in the proprietary rooming houses or boarding homes in which purely residential needs were the primary concern of the entrepreneurial provider.

The NIMH 1976 inventory attempted to recognize and account for these different community residential programs by asking respondents to indicate whether the program was a "halfway house," "community residence," or "other transitional service." Although the definitions for halfway house and community residence attempted to distinguish between transitional and long-term programs, many programs described by respondents as transitional also reported utilization data and licensing information indicating that they were, in fact, long-term residential programs. Thus, facilities cannot be easily classified as either transitional or long-term from the inventory question on type of program.

The narrative comments provided by some respondents on the inventory indicate the dilemmas they faced in classifying their own programs. A respondent from upstate New York who checked the halfway house category wrote that:

> . . . our program has some features of both halfway houses and long-term community residential programs. Some residents remain with us on a long-term basis. Those who graduate to cooperative apartments get ongoing support from our program. Currently, we have 14 persons in cooperative apartments. (edited by HHI staff)

When asked for the types of services provided by the facility, the respondent further indicated that the program provides a number of vocational and rehabilitative services both within the facility and by agreement or contract with outside agencies. In addition, the program was said to provide:

> . . . ongoing support for graduates who move together to cooperative apartments and to their own apartments. We provide a Thursday night social, dinners and holiday celebrations, and ongoing help with other problems in such areas as health or finances. We employ exresidents (graduates) as staff in the cooperative apartment (edited by HHI staff).

This facility, with 14 beds and 14 residents at the time of the inventory, is relatively short-term. Fewer than 75 percent of the residents had been in the facility 6 months or longer, and there had been 18 admissions during the past year, both figures indicating a fairly rapid turnover. Holding a residence license as a "hostel," from New York State's Department of Mental Hygiene, the respondent was uncertain if the *total* program operating under a single auspice was a halfway house or a community residential program.

A case-by-case inspection of facilities that reported little turnover (and are probably long-term care programs) disclosed that a number of facilities responding as "halfway houses" in 1976 (and in 1973 as well) would be more realistically classified as long-term community residential programs. In Chicago, for example, one facility indicated that 235 of its 249 residents had been continuously in residence for 6 or more months. Halfway houses typically move clients through in a year or less, and thus the expected ratio of residents who had been in the program 6 months or longer would be close to 50 percent, not the more than 90 percent this facility reported. Still more revealing of the program's long-term emphasis was its report that it is a licensed Intermediate Care Facility — a type of nursing home. An analysis of other 1976 inventory cases reporting over 70 percent of residents staying longer than 6 months disclosed that in Chicago alone, seven facilities describing themselves as "halfway houses" held licenses as Intermediate Care Facilities and averaged 197 beds per facility. Addresses of several of these facilities indicate that they are converted inns, hotels, or apartment buildings that now provide care primarily for mentally disabled persons. For most of these programs, well over 80 percent of their clients have resided in the facility for 6 months or longer. Clearly, to classify these facilities as halfway houses would severely disrupt the statistical profile of other, smaller transitional programs, which average fewer than 25 beds per residence.

To portray more accurately the characteristics of transitional *and* nontransitional residential programs, facilities were classified by means of program indicators that delineated their transitional or long-

term characteristics. Thus, the following taxonomy was developed.

Type 1: Residences for Children and Adolescents. — Programs admitting only persons under age 22 were classified as facilities for children and adolescents. Twenty-eight facilities serving a total of 275 young clients were placed in this category. In comparison with programs for adults, youth-oriented facilities were smaller, cost more, provided more staff time per resident, and offered more in-house services.

Type 2: Transitional Residences for Adults. — Residential facilities for adults which reported rapid turnover of clients were classified as transitional. Two indicators of turnover were employed. First, a facility was considered transitional if it reported that fewer than 75 percent of its residents had stayed longer than 6 months. (A lower cutoff point of 60 percent or 50 percent would have produced virtually identical results, because the average proportion of residents staying over 6 months was 34 percent for facilities meeting the initial 75 percent criterion.)

Second, since more than 20 facilities did not report on length of stay, a second indicator of turnover was used — admissions per 100 beds. If the facility did not report on length of stay but reported more than 100 admissions per 100 beds for the previous year, it was classified as transitional. Finally, the few remaining facilities that provided neither length of stay nor admissions data were telephoned to assess the type of program. In all, 127 facilities were classified as adult transitional. The median number of beds reported by these facilities was 10, significantly lower than the 32 reported by nontransitional programs.

Type 3: Nontransitional Residences for Adults. — Facilities reporting low turnover (more than 75 percent of clients staying 6 months and longer; or fewer than 100 admissions per 100 beds) were classified as nontransitional (long-term) community residential facilities. These programs offer fewer services, provide fewer staff hours per client, and are more likely to be operated under proprietary auspices (65 percent).

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APPENDIX A

Facsimile of 1976 HEW Form: Inventory of Psychiatric Halfway Houses and Community Residences

(N's refer to number of facilities for which information was obtained)

(1)* and (2)* were questions asking the respondent to indicate the correct name, address and telephone number for the facility. N=228

(3)* Please check the classification below which best describes your facility. Check only one.

a. Halfway House — A nonmedical residential facility with three or more beds which has round-the-clock or live-in staff and provides room, board, supervised living and other supportive or rehabilitation services to people with *mental health problems.* The program of the facility is transitional in nature, designed either to provide an alternative to inpatient care, to shorten the length of hospitalization, or to assist clients in preparing for independent living following discharge from an inpatient facility.

b. Community Residence — A nonmedical residential facility with three or more beds which has round-the-clock or live-in staff who provide supervision and support on a long-term basis to people with *mental health problems.*

c. Other Transitional Services — Please specify and give brief description:

N=228

(4a)* Does your facility come under the administration of a larger hospital, medical center complex, community mental health center, rehabilitation center, or other larger agency or organization?

1 Yes — Enter name and address of the larger complex
2 No — Go to Question 5

N=228

(4b)* Are the persons served in this facility usually limited to patients or clients of this larger agency or organization?

1 Yes
2 No

N=78

(5)* Place an "X" in only ONE box below to indicate the type of organization legally responsible for the operation of this facility:

Type of Control

1 State
2 City
3 County
4 City-County
5 Hospital District
6 Proprietary (Privately owned and managed for profit)
7 Church
8 Other Nonprofit
9 Other (Specify):

N=228

(6)* Does your facility accept persons of all ages including infants and children?

1 Yes (Go to Q. 7)
2 No (Answer A and B)

A. Minimum age accepted is _____ (If there is no minimum age, enter 0)
B. Maximum age accepted is _____ (If there is no maximum age, enter 99)

N=226

(7)* Do you accept (Check only ONE box):

1 Males only
2 Females only
3 Both males and females

N=228

(8)* Which of the following categories of persons does your facility primarily serve? (Check only one) If more than one, check that category which has the highest percentage of residents.

1 People with mental health problems
2 Mentally retarded
3 Alcohol abusers
4 Drug abusers (All drugs except alcohol)
5 Disturbed children or juvenile delinquents
6 Other (Please describe)

N=228

(9) Admission requirements (Check all that apply): Residents must:

1 Be referred from mental health professional or agency
2 Be under care of psychiatrist or other physician
3 Be able to pay for services
4 Be able to benefit from rehabilitation
5 Be without disabling physical condition
6 Be able to manage personal needs
7 Be employable
8 Engage in outside activity (e.g., volunteer work, attend school, etc.)
9 Engage in activity programs within house
10 Agree to share in housekeeping and maintenance tasks
11 Other (Specify):

N=168

(10) Enter below the number of staff and hours worked for persons who actually worked or were scheduled to work (e.g., on vacation, on sick leave) during the week of February 15-21, 1976.

Regular Staff — Includes owners, managers, cooks, helpers, and all other paid employees (excluding residents of the facility) who work on a regular basis in the facility. Exclude individuals who receive no salary. Include persons regularly working in this facility who may be paid by another agency (e.g., school teacher from the local school system).

Trainees — Include interns (e.g., medical or psychiatric) and other trainees (if on the payroll) regardless of the number of hours worked in the week.

Consultants — Include only those working on a regularly scheduled work week.

Volunteers — Include only those working on a regular schedule without pay. Be sure to exclude those who are currently residents.

Residents — Include only those who are paid salaries and/or receive some or all of their room and board in exchange for their services. Do NOT include persons not considered residents such as owners or live-in administrators or managers.

Staff	Total Number of Persons	Scheduled Hours Week of February 15-21
1. Regular Staff: Full-time (work 35 hrs. or more a week)	N=168	N=167
Part-time (work less than 35 hrs. a week)	N=168	N=167
2. Trainees	N=168	N=167
3. Consultants	N=168	N=160
4. Volunteers	N=168	N=164
5. Residents	N=168	N=165

(11) Which of the following types of services are provided by the staff of your facility or by agreement or contract with an outside agency? (Check all that apply):

Type of Service	Provided by Your Facility	Provided by Agreement or Contract With Outside Agency
1. Medical examination	N=168	N=168
2. Psychiatric evaluation	N=168	N=168
3. Individual counseling or therapy	N=168	N=168
4. Group counseling or therapy	N=168	N=168
5. Family therapy	N=168	N=168
6. Alcoholics anonymous services	N=168	N=168
7. Planned recreation activity program	N=168	N=168
8. House meetings	N=168	N=168
9. Job placement	N=168	N=168
10. Vocational rehabilitation and employment counseling	N=168	N=168
11. Religious services	N=168	N=168
12. Detoxification services	N=168	N=168
13. Counseling ex-residents	N=168	N=168
14. Educational program	N=168	N=168
15. Assistance in finding long-term housing	N=168	N=168
16. Others (Please specify types)	N=168	N=168

(12)* How many beds are regularly set up and staffed for use by residents? (Include all beds whether or not they are in use at the present time. Do not include beds occupied by persons not considered residents such as owners or live-in administrators or managers.)

Number of beds _____ N=228

(13)* How many residents stayed in this facility last night? (Do not include staff or owners)

Number of residents _____ N=228

(14)* Of the residents entered in Question 13, how many have been continuously resident in your facility for six months or more?

Number _____ N=208

(15)* How many admissions were there to this facility between January 1, 1975 and December 31, 1975? (If a person is admitted more than once, count each admission)

Number of admissions _____ N=191

(16) Of the total admissions in Question 15, how many were in each of the groups shown below?

Prior Treatment Category	Both Sexes
1. Entered facility on convalescent leave or discharge from psychiatric hospital _____	N=168
2. Entered facility from community, without prior psychiatric hospitalization _____	N=168
3. Entered facility from community, but had been hospitalized previously for mental health problems _____	N=168
4. Entered facility on release from a correctional institution _____	N=168
Total (Equal to number given in Question 15) _____	N=146

(17) How many days of residential care (the sum of the daily resident count from January 1 through December 31) were provided in 1975?

Number of days _____ N=161

(18) How many discharges (including deaths) were there from your facility between January 1, 1975 and December 31, 1975?

Number of live discharges _____ N=168
Number of deaths _____ N=168
Total number of discharges and deaths _____ N=157

(19)* Is your facility currently licensed (including approval pending) by a State, county or local government agency?

Yes, licensed (including approval pending) Go to Question 20
No, not licensed nor approval pending Go to Question 21 N=228

(20)* Under what type of license (including approval pending) does your facility operate? (Check only one box below)

1. Halfway house
2. Rooming house
3. Boarding house
4. Foster home
5. Intermediate care facility
6. Apartment house
7. Multiple family dwelling
8. Residential or sheltered care facility
9. Other (Specify): N=228

(21)* What is your basic monthly charge (regardless of payment source) for a resident's lodging, meals, and routine care?

Highest monthly charge for a resident ____ N=199
Lowest monthly charge for a resident ____ N=188
Average monthly charge for a resident ____ N=206

(22) Annual Expenditures. Please enter below the amount of money spent by your facility during the year ending December 31, 1975. (If you are unable to report for the period requested, please provide the information for a period more convenient for you and indicate below)

Complete year ending 12/31/75
Complete year ending ____
Partial year (Specify):
From _____ to _____ N=168
Personnel expenditures $____ N=156
(Salaries and wages, employee benefits, and consultant fee expenses)
Other expenditures $____ N=156
Total expenditures $____ N=136

(23) How is your halfway house or community residence supported? Total Income

1. Resident fees (excluding fees paid by third parties such as Medicare, commercial insurance, etc.) N=168
2. Medicaid N=168
3. Medicare N=168
4. Private insurance companies N=168
5. Champus N=168
6. State government funds:
   a. Vocational rehabilitation N=168
   b. Social services (Title XX) N=168
   c. Aging programs N=168
   d. Other State government funds N=168
7. Local government funds:
   a. Labor and manpower programs (CETA) N=168
   b. Housing and community development programs (HUD) N=168
   c. Revenue sharing N=168
   d. Other local government funds N=168
8. Federal government funds N=168
9. Donations (Including free contributions from individuals, corporations, charitable organizations, united community chests, foundations, and others) N=168
10. Other fund revenue (Including gains on sale of assets, own fund raising activities, interest earned, and other miscellaneous income) N=168

TOTAL N=129

* These questions were administered by telephone to facilities not returning the inventory form, in an attempt to improve the response rate.

Table I. Number and percent distribution of residents in psychiatric halfway houses and community residences by type of facility and selected characteristics: United States, 1976

Characteristics	Type of facility							
	All types		Children and adolescents		Adult transitional		Adult nontransitional	
	Number of residents	Percent	Number of residents	Percent	Number of residents	Percent	Number of residents	Percent
Total all facilities	6,897	100.0%	273	100.0%	2,672	100.0%	3,952	100.0%
Sex Restrictions on Admissions								
Serves both sexes...	6,207	90.0	136	49.8	2,432	91.0	3,639	92.1
Serves males only...	283	4.1	75	27.5	89	3.3	119	3.0
Serves females only.	407	5.9	62	22.7	151	5.7	194	4.9
Ownership								
Government.....	307	4.5	-	-	307	11.5	-	-
Proprietary.....	3,824	55.4	46	16.8	811	30.4	2,967	75.1
Nonprofit.....	2,766	40.1	227	83.2	1,554	58.1	985	24.9
Bed Size								
4-10 beds.....	331[a]	4.9	95	34.8	176	6.6	60[a]	1.5
11-15 beds.....	584	8.6	53	19.4	470	17.6	61	1.6
16-25 beds.....	1,092	16.0	79	28.9	734	27.4	279	7.2
25 or more beds.....	4,814	70.5	46	16.8	1,292	48.3	3,476[a]	89.7
Geographic Region[b]								
Northeast.....	1,340	19.4	108	39.6	999	37.4	233	5.9
North Central.....	3,269	47.4	61	22.3	669	25.0	2,539	64.2
South.....	666	9.7	30	11.0	573	21.4	63	1.6
West.....	1,622	23.5	74	27.0	431	16.1	1,117	28.3
Number of facilities reporting.....	226		28		133		65	

[a] By bed size the "adult nontransitional" category and the total "all types" reported one less facility with a decrease in total residents of 76. Percents are therefore calculated on a total resident population of 3,876 for "adult nontransitional" facilities and a total resident population of 6,821 for "all types" combined.

[b] See definition of geographic regions in appendix F for the breakdown of States into the four regions.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table II. Minimum and maximum age restrictions on admission to psychiatric halfway houses and community residences by type of facility: United States, 1976

Minimum age accepted	Number of facilities reporting	Maximum age accepted					
		16 Yrs. and under	17-21 Years	22-44 Years	45-64 Years	65 Yrs. and over	No maximum indicated
				All types			
Total with restrictions	226	4	24	13	35	39	111
16 Years and under...	65	4	24	3	8	9	17
17-18 Years.....	142	-	-	8	26	28	80
19-21 Years.....	9	-	-	2	1	-	6
22 Years and over....	10	-	-	-	-	2	8
				Children and adolescents			
Total with restrictions	28	4	24	-	-	-	-
16 Years and under...	28	4	24	-	-	-	-
17-18 Years.....	-	-	-	-	-	-	-
19-21 Years.....	-	-	-	-	-	-	-
22 Years and over....	-	-	-	-	-	-	-
				Adult transitional			
Total with restrictions	133	-	-	8	26	27	72
16 Years and under...	31	-	-	2	6	9	14
17-18 Years.....	95	-	-	4	19	18	54
19-21 Years.....	5	-	-	2	1	-	2
22 Years and over....	2	-	-	-	-	-	2
				Adult nontransitional			
Total with restrictions	65	-	-	5	9	12	39
16 Years and under...	6	-	-	1	2	-	3
17-18 Years.....	47	-	-	4	7	10	26
19-21 Years.....	4	-	-	-	-	-	4
22 Years and over....	8	-	-	-	-	2	6

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table III. Percent distribution of psychiatric halfway houses and community residences, by type of facility, licensure status, and type of ownership: United States, 1976

Type of ownership	Type of facility			
	All types	Children and adolescents	Adult transitional	Adult non-transitional
All types				
Total facilities.....	100.0%	100.0%	100.0%	100.0%
Not licensed.....	25.0	3.6	32.3	20.0
Operating with license..	75.0	96.4	67.7	80.0
Halfway house license.	24.0	25.0	31.6	7.7
Other type license....	51.0	71.4	36.1	72.3
Number of facilities reporting.....	(226)	(28)	(133)	(65)
Government				
Total facilities.....	100.0%	-	100.0%	-
Not licensed.....	40.0	-	40.0	-
Operating with license..	60.0	-	60.0	-
Halfway house license.	33.3	-	33.3	-
Other type license....	26.7	-	26.7	-
Number of facilities reporting.....	(15)	-	(15)	-
Proprietary				
Total facilities.....	100.0%	100.0%	100.0%	100.0%
Not licensed.....	14.0	-	28.6	9.5
Operating with license..	86.0	100.0	71.4	90.5
Halfway house license.	4.0	-	14.3	-
Other type license....	82.0	100.0	57.1	90.5
Number of facilities reporting.....	(57)	(1)	(14)	(42)
Nonprofit				
Total facilities.....	100.0%	100.0%	100.0%	100.0%
Not licensed.....	28.0	3.7	31.7	39.1
Operating with license..	72.0	96.3	68.3	60.8
Halfway house license.	30.0	25.9	33.7	21.7
Other type license....	42.0	70.4	34.6	39.1
Number of facilities reporting.....	(154)	(27)	(104)	(23)

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table IV. Average number of beds per halfway house or community residence by type of facility and selected characteristics: United States, 1976

Selected characteristics	Type of facility			
	All types	Children and adolescents	Adult transitional	Adult non-transitional
Total all facilities.....	35.3	11.7	22.7	71.9
Sex Restrictions on Admissions				
Serves both sexes.....	41.9	15.4	24.9	81.8
Serves males only.....	11.4	9.4	11.9	15.2
Serves females only.....	15.7	9.9	12.7	29.0
Ownership				
Government.....	24.4	-	24.4	-
Proprietary.....	78.2	51.0	59.7	85.0
Nonprofit.....	20.4	10.2	17.4	46.8
Geographic Region				
Northeast.....	21.1	11.1	24.6	18.8
North Central.....	60.0	8.0	26.9	111.6
South.....	17.6	12.3	18.6	13.2
West.....	40.3	21.2	20.3	72.9
Population Size of Area[a/]				
Urban area total.....	35.6	11.7	22.2	71.2
Central cities total..	42.8	9.6	27.0	80.5
Urban fringes total...	32.3	10.2	18.3	82.0
Outside urbanized area	15.1	16.5	13.9	19.0
Rural.....	21.8	-	33.0	14.3
Number of facilities reporting.....	225	28	133	64

[a/] See definition of population size of area included in appendix F.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table V. Average expenditures per resident day in psychiatric halfway houses and community residences by type of facility and selected facility characteristics: United States, 1976

Selected facility characteristics	Type of facility			
	All types	Children and adolescents	Adult transitional	Adult non-transitional
All types - United States	$ 18	$ 37	$ 16	$ 12
Auspice				
Government	22	-	22	-
Proprietary	13	21	13	12
Nonprofit	19	38	16	11
Bed Size Group				
4-10 Beds	$ 23	$ 46	$ 16	$ 25
11-15 Beds	20	38	17	15
16-25 Beds	17	30	15	8
25 Or more beds	14	21	18	8
Geographic Region				
Northeast	$ 18	$ 39	$ 15	$ 14
North Central	18	47	14	9
South	16	21	16	16
West	21	37	21	8
Sex Restrictions				
Serves both sexes	$ 16	$ 24	$ 16	$ 11
Serves males only	24	37	19	20
Serves females only	27	66	17	8
Number of facilities reporting	126	17	86	23

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table VI. Mean annual expenditures per facility and per admission by type of facility and sex served, psychiatric halfway houses and community residences: United States, 1976

Sex served and expenditure ratios	Type of facility			
	All types	Children and adolescents	Adult transitional	Adult non-transitional
All Facilities				
Expenditure per facility.....	$118,010	$130,203	$104,989	$157,635
Expenditure per admission.....	5,503	15,260	2,537	10,000
Number of facilities reporting.....	(134)	(17)	(92)	(25)
Serves Both Sexes				
Expenditure per facility.....	$130,093	$113,829	$118,683	$181,634
Expenditure per admission.....	4,382	11,587	2,428	8,692
Number of facilities reporting.....	(101)	(9)	(73)	(19)
Serves Males Only				
Expenditure per facility.....	$ 84,768	$140,778	$ 64,077	$ 65,266
Expenditure per admission.....	14,180	28,773	3,633	27,182
Number of facilities reporting.....	(15)	(4)	(8)	(3)
Serves Females Only				
Expenditure per facility.....	$ 77,910	$156,468	$ 43,862	$ 98,011
Expenditure per admission.....	4,481	9,092	2,402	5,957
Number of facilities reporting.....	(18)	(4)	(11)	(3)

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table VII. Distribution of psychiatric halfway houses and community residences by type of facility, licensure status, and size (based on number of beds): United States, 1976

Size (based on number of beds)	Type of facility			
	All types	Children and adolescents	Adult transitional	Adult non-transitional
All sizes				
Total facilities	100.0%	100.0%	100.0%	100.0%
Not licensed	25.0	3.6	32.3	20.0
Operating with license	75.0	96.4	67.7	80.0
Halfway house license	24.0	25.0	31.6	7.7
Other type license	51.0	71.4	36.1	72.3
Number of facilities reporting	(226)	(23)	(133)	(64)
1-10 Beds				
Total facilities	100.0%	100.0%	100.0%	100.0%
Not licensed	28.0	6.3	46.4	11.1
Operating with license	72.0	93.7	53.6	88.9
Halfway house license	23.0	31.3	21.4	11.1
Other type license	49.0	62.4	32.2	77.8
Number of facilities reporting	(53)	(16)	(28)	(9)
11-15 Beds				
Total facilities	100.0%	100.0%	100.0%	100.0%
Not licensed	22.0	-	25.6	20.0
Operating with license	78.0	100.0%	74.4	80.0
Halfway house license	37.0	33.3	41.8	-
Other type license	41.0	66.7	32.6	80.0
Number of facilities reporting	(54)	(6)	(43)	(5)
16-25 Beds				
Total facilities	100.0%	100.0%	100.0%	100.0%
Not licensed	29.0	-	32.6	26.7
Operating with license	71.0	100.0	67.5	73.3
Halfway house license	27.0	-	34.9	13.3
Other type license	44.0	100.0	32.6	60.0
Number of facilities reporting	(63)	(5)	(43)	(15)
26-290 Beds				
Total facilities	100.0%	100.0%	100.0%	100.0%
Not licensed	20.0	-	26.3	17.1
Operating with license	80.0	100.0	73.7	82.9
Halfway house license	9.0	-	15.8	5.7
Other type license	71.0	100.0	57.9	77.2
Number of facilities reporting	(55)	(1)	(19)	(35)

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table VIII. Percent distribution of facilities by type of facility and bed size group: United States, 1976

Bed size group	Total	Type of facility: Children and adolescents	Adult transitional	Adult non-transitional
Total - All facilities....	100.0%	100.0%	100.0%	100.0%
4 beds and under....	0.4	3.6	-	-
5- 9 beds.....	15.6	42.8	12.0	10.9
10-14 beds.....	27.1	28.6	35.3	9.4
15-19 beds.....	17.8	21.4	21.1	9.4
20-24 beds.....	12.9	-	15.8	12.5
25-34 beds.....	6.2	-	6.0	9.4
35-49 beds.....	4.0	-	3.8	6.3
50-74 beds.....	4.9	3.6	1.5	12.5
75-99 beds.....	1.8	-	1.5	3.1
100 beds and over...	9.3	-	3.0	26.5
Median bed size.....	(16)	(10)	(15)	(32)
Number of facilities reporting.....	225	28	133	64

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table IX. Number of psychiatric halfway houses and community residences reporting both years by licensure status and type of license: United States, 1973 and 1976

Licensure status, 1973	Licensure status, 1976									
	Totals	Halfway house	Rooming house	Boarding house	Foster home	Intermediate care facility	Multiple family dwelling	Residential or sheltered care facility	Other	No license
Total facilities reporting.....	116	33	3	9	1	9	1	18	14	28
Halfway house.....	20	10	-	-	-	1	-	1	2	6
Rooming house.....	6	1	1	2	-	-	1	-	-	1
Boarding house....	11	4	1	3	-	-	-	-	2	1
Multiple family dwelling.....	2	1	-	-	-	-	-	-	-	1
Residential care facility.....	16	4	-	1	-	3	-	5	2	1
Other.....	7	1	-	-	-	1	-	4	-	1
No license.....	54	12	1	3	1	4	-	8	8	17

Source: NIMH 1973 Inventory of Halfway Houses for the Mentally Ill and Alcoholics and NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table X. Number and percent distribution of total revenues for psychiatric halfway houses and community residences by funding source and type of facility: United States, 1976

Funding source	Type of facility							
	All types		Children and adolescents		Adult transitional		Adult nontransitional	
	Amount	Percent dist.	Amount	Percent dist.	Amount	Percent dist.	Amount	Percent dist.
Total receipts from all sources...	$17,346,718	100.0%	$1,953,438	100.0%	$9,755,710	100.0%	$4,637,570	100.0%
Receipts from direct services.....	8,297,913	50.8	232,117	11.9	4,605,149	47.2	3,460,647	74.6
Resident fees.....	6,186,954	37.9	232,117	11.9	3,540,068	36.4	2,405,769	51.9
Medicaid.....	2,097,756	12.8	-	-	1,042,878	10.7	1,054,878	22.7
CHAMPUS.....	12,923	0.1	-	-	12,923	0.1	-	-
Insurance (pvt. & vol.).....	280	0.0	-	-	280	0.0	-	-
State government funds.....	5,069,384	31.0	947,003	48.5	3,117,148	32.0	1,005,233	21.7
Vocational rehabilitation.....	481,642	2.9	24	0.0	470,618	4.8	11,000	0.2
Social services (Title XX).....	1,220,804	7.5	491,467	25.2	585,262	6.0	144,075	3.1
Other State government funds....	3,366,938	20.6	455,512	23.3	2,061,268	21.2	850,158	18.4
Local government funds.....	1,890,939	11.6	545,847	27.9	1,315,804	13.5	29,288	0.6
Labor & manpower programs (CETA)	49,034	0.3	12,125	0.6	33,621	0.3	3,288	0.1
Housing & community development program (HUD).....	37,000	0.2	31,000	1.6	6,000	0.1	-	-
Other local government funds....	1,804,905	10.9	502,722	25.7	1,276,183	13.1	26,000	0.5
Federal Government funds.....	214,419	1.3	109,292	5.6	102,427	1.0	2,700	0.1
Fundraising.....	874,063	5.3	119,179	6.1	615,182	6.3	139,702	3.0
Mean revenues per facility.....	$148,607		$325,573		$121,946		$193,232	
Number of facilities reporting....	(110)		(6)		(80)		(24)	

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table XI. Type of affiliation of psychiatric halfway houses and community residences by type of facility: United States, 1976

Type of affiliation	Type of facility			
	All types	Children and adolescents	Adult transitional	Adult non-transitional
Total reporting facilities.	226	28	133	65
State and county mental hospital.....	3	-	3	-
Private psychiatric hospital.....	5	1	4	-
Non-Federal general hospital with separate psychiatric service....	4	-	4	-
Residential treatment center.....	14	12	2	
Non-Federal outpatient psychiatric clinic.....	4	-	4	-
Day/night treatment facility.....	4	-	2	2
Federally funded community mental health center.....	6	-	5	1
Halfway house or community residence.....	5	-	4	1
Nonfederally funded community mental health center.....	2	-	2	-
Social service agency....	15	4	10	1
Vocational rehabilitation	7	-	6	1
County government.....	4	1	3	-
Other.....	2	1	1	-
No affiliation.....	151	9	83	59

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table XII. Number of halfway houses and community residences, beds and beds per 100,000 population size of area in which located: United States, 1976

Population size of area[a]	Facilities		Beds		Beds per 100,000 population[b]
	Number	Percent	Number	Percent	
Total, all areas.....	228	100.0%	7,965	100.0%	3.9
Urban area total.....	222	97.4	7,850	98.6	5.2
Central cities total....	140	63.1	5,965	76.0	9.3
500,000 over.....	55	39.3	3,952	66.3	12.4
Cities under 500,000..	85	60.7	2,013	33.7	6.2
Urban fringes total.....	38	17.1	1,229	15.6	2.2
10,000		97.4	1,214	98.8	3.8
Places under 10,000...	1	2.6	15	1.2	0.1
Outside urban area.....	44	19.8	656	8.4	2.1
Rural.....	6	2.6	115	1.4	0.2

[a] Area population size groups are based on the 1970 census of the resident population; see definition of population size of area included in appendix F.

[b] The population used in the calculation of these rates is the U.S. Resident Population 1970.

Sources: Number of Inhabitants - U.S. Summary, Vol. 1-43.
NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

APPENDIX C

The Use of a Guttman Scaling Program To Determine the Interrelationships of Admission Requirements for Halfway Houses and Community Residences

Four items on the list of admission requirements in the 1976 Inventory of Psychiatric Halfway Houses and Community Residences were found to be highly interrelated and to comprise a scale of admissions criteria. These four items include that the resident (1) be able to engage in in-house activities, (2) be able to engage in outside activities, (3) agree to share in housekeeping and maintenance tasks, and (4) be employable.

Using a Guttman scaling program, (1) and (2) above were scored as a single dummy variable (ACTIVITIES). The scoring for the ACTIVITIES variable was 0 if the facility did not require the residents to engage in either in-house or outside activities and 1 if the facility did require either type of activity. Overall, 79 percent of the facilities required one or the other admission criteria. The third item of housekeeping and maintenance tasks was scored in the same manner and called MAINTAIN; 67 percent of the facilities reported this requirement. The last variable included in the admissions requirements scale was that the resident be employable. It was similarly scored, called EMPLOY, and required by 23 percent of the facilities.

What differentiates the Guttman scale approach from simpler correlative techniques is that it examines scales with regard to the potential hierarchical nature of the variables; i.e., do the various scale scores 0 through 3 describe specific types or patterns of items in the scale? The Guttman Scalogram results for these admission requirements are shown in Table XIII. The scale score on the left is composed of the simple addition of the score for each admission criterion and therefore ranges from 0 to 3. The table demonstrates a clear hierarchy of requirements. Where the scale score is 2, only 1 of 74 facilities required their residents to be employable. Thus, the EMPLOY criterion is rarely in effect if the facility does not also require the other two criteria of ACTIVITIES and MAINTAIN. This hierarchical pattern is also evident for scale score 1. Twenty-three facilities fell in this category, with none requiring employability for admission and only 2 requiring participation in housekeeping and maintenance tasks. A very high coefficient of reproducibility for this scale (.988) confirms the hierarchical relationship among the three admission variables.

The incidence of these selected admission criteria are highly related to the level of services found in the facility as well as to certain resident characteristics. Specifically, facilities with a larger proportion of residents staying longer than 6 months are significantly less likely to report these admission requirements ($r=.31$, $p<.01$). On the other hand, facilities having more admission requirements and expecting a higher level of resident activity are more likely to be licensed, and to be licensed as halfway houses rather than boarding houses, intermediate care facilities, or any other type of facility. Further, as discussed below, facilities requiring more resident activity in and around the facility and expecting the resident to be emplolyable are significantly more likely to provide in-house counseling services ($r=.20$ $p<.05$), external counseling services ($r=.29$, $p<.05$), and external facilitative services, i.e., job training and vocational rehabilitation ($r=.25$, $p<.05$). Thus, clusters of services and admission requirements are evident and influence the degree to which the facility is rehabilitation-oriented.

Table XIII. Guttman scalogram of selected admission requirements for halfway houses and community residences reporting admission requirements: United States, 1976

Admission requirements	Proportion of facilities with requirement
Engage in outside activities or activities within the house (ACTIVITIES)	79%
Agree to share in housekeeping and maintenance tasks (MAINTAIN)	67
Be employable	23

		Requirements for Admission (N=168)					
		EMPLOY		MAINTAIN		ACTIVITIES	
Scale Score	Total	Yes	No	Yes	No	Yes	No
3	37	37		37		37	
2	74	1	73	73	1	74	
1	23		23	2	21	21	2
0	34		34		34		34

Coefficient of Reproducibility = .988

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

APPENDIX D

The Use of a Factor Analysis Technique To Study the Interrelationship Between Internal and External Services Provided to Halfway-House Residents

To more concisely present the array of services available to residents, the statistical technique of factor analysis was used. This procedure extracted six orthogonal factors, the first three of which accounted for over 75 percent of the variance. The first factor extracted from the service variable has been labeled *In-House Counseling Services* because of the four variables with loadings greater than .60 (all positive as shown in table XIV). These items include: (1) group counseling or therapy, (2) house meetings, (3) individual counseling or therapy, and (4) assistance with long-term housing — all internal services. These services had much lower scores in factors 2 and 3. Factor 2 was closely correlated with (1) vocational training, (2) job placement, (3) educational program, (4) planned recreation, and (5) assistance with long-term housing. The training and vocational foci of these external services, combined with the observation that only external services show high loadings for factor 2, led us to label this factor *External Facilitative Services*. The third factor is, in several respects, a mirror image of the first. However, only *external* services show loadings of .50 or higher on factor 3. These include (1) individual counseling or therapy, (2) group counseling or therapy, and (3) family therapy.

The items selected to construct scales of services are shown in table XV. Each service was scored 0 to 1, with 1 indicating the presence of the service. Thus, facilities that provided group counseling or therapy and house meetings would have a score of 2 for the In-House Counseling Services scale. A facility with external job placement services, external vocational training, and external educational programs, but without planned recreation or assistance with long-term housing through external agencies would have a score of 3 (1+1+1+0+0) on the External Facilitative Services scale.

These scales differentiate among types of facilities, as clearly shown in table XV. Scores on In-House Counseling Services and External Facilitative Services for facilities serving children and adolescents are higher than for transitional or nontransitional adult programs. However, facilities for children and adolescents report very few external counseling services, reserving this function for in-house staff.

In adult facilities, transitional programs provide a substantially higher level of each type of service than the nontransitional facilities. In other words, nontransitional facilities have lower levels of in-house services than transitional programs and are less likely to augment existing services through use of external agencies.

Table XIV. Selected results of orthogonal factoring of in-house and externally provided services for halfway houses and community residences: United States, 1976

Services[a]	Factor 1[b]	Factor 2[b]	Factor 3[b]
Group counseling or therapy (IN)	*.70*	.19	-.23
House meetings (IN).....	*.70*	.11	.10
Individual counseling or therapy (IN).....	*.66*	.15	-.24
Assistance with long-term housing (IN).....	*.62*	.05	.19
Vocational training (EX).....	.13	*.69*	.12
Job placement (EX).....	.15	*.66*	.27
Educational program (EX).....	.17	*.63*	-.03
Planned recreation (EX).....	-.03	*.58*	.15
Assistance with long-term housing (EX).....	.09	*.55*	.26
Individual counseling or therapy (EX).....	-.02	.29	*.81*
Group counseling or therapy (EX).....	-.01	.39	*.76*
Family therapy (EX).....	.09	.19	*.54*
Number of facilities reporting..		166	

[a] IN denotes in-house service; EX denotes that the service is provided by agreement or contract with an external agency.

[b] Scores in italics indicate the variables selected for each scale.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table XV. Level[a] of services in halfway houses and community residences by target group and type of program: United States, 1976

Target groups	In-house counseling and therapy services[b]	External counseling and therapy services[b]	External facilitative services[b]
Children and adolescents (N=20).....	3.15	.25	1.75
Adults			
Transitional (N=104)....	2.94	.96	1.52
Nontransitional (N=42)..	2.31	.36	1.07
	F = 3.91 p < .025	F = 7.20 p < .001	F = 1.62 p < n.s.

[a] Three factors derived from the matrix of 15 internal and 15 outside services are shown. The scores represent simple addition of the items with high factor loadings (scored 0, 1).

[b] The In-House Counseling and Therapy Services scale includes group counseling or therapy, house meetings, individual counseling or therapy and assistance with long-term housing; External Counseling and Therapy Services scale includes individual counseling or therapy, group counseling or therapy and family therapy; the External Facilitative Services scale includes vocational training, job placement, educational program, planned recreation and assistance with long-term housing.

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

APPENDIX E

A Multivariate Regression Model for Determining the Costs of Community Residential Services to the Psychosocially Disabled

THE DETERMINANTS OF RESIDENTIAL COSTS

Table XVI presents a partial replication of a model for predicting program costs developed from an earlier analysis of halfway-house data (Piasecki and Pittinger 1977). Two features of this model should be noted. First, a dummy variable indicates the transitional or nontransitional orientation of the program (based on the proportion of residents staying over 6 months and scored 0, 1). Second, the regression is applied *only* to facilities which serve adults, because the high correlation between service to children and per diem costs could obscure significant cost factors in adult facilities. Cost variation in juvenile programs is considered separately below.

INDEPENDENT VARIABLES

Level of Services

A zero order correlation matrix was developed and is shown in table XVII. The costs for adult residential programs are influenced by the level of services provided in-house or through referral to other agencies. In-house counseling services are positively related to per diem costs, but higher levels of external counseling services and external facilitative services are associated with lower costs. Since in-house counseling services imply the use of professional and other support staff *in-house*, the positive association with the "average number of staff hours per resident" is consistent with the relationship of cost to services ($r=.20$ $p<.05$).

Staff Hours Per Resident

Prior reviews of expenditure patterns have shown that staff salaries and wages typically comprise over 50 percent of the facility's annual budget. It is not surprising, then, that the ratio of staff hours per resident is highly correlated with cost ($r=.46$), $p<.005$). This variable alone accounts for about 20 percent of the total variation in cost.

Number of Beds

In testing for the presence of economies of scale (lower unit costs as facility size increases), the number of beds was found to be somewhat *negatively* related to costs ($r=.17$ $p<.05$). However, in the final regression, size made no significant independent contribution in accounting for variation in cost.

COST DETERMINANTS FOR ADULT FACILITIES

The multiple regression equation (table XVI) showed that the best predictor of per diem costs was the ratio of staff hours per resident. The greater the number of scheduled staff hours per resident, the higher the per diem resident cost. The transitional or nontransitional orientation of the facility (the proportion of residents staying over 6 months) did not contribute significantly to the regression outcome. However, as shown in table XVII, the proportion of long-term residents was negatively related to in-house services, which in turn were associated with higher costs. Further, the greater the proportion of long-term residents, the fewer the staff hours per resident. Thus, two variables related to the transitional nature of the facility — the service pattern and utilization of staff — not only "explain" substantial cost variation, but also point to differing styles of operation. Yet the regression model displayed here accounts for only about 30 percent of the variation in per diem cost. Neither size nor proprietary auspice was found to explain cost variations. Regional variations or urban/rural differences in wage scales or cost-of-living rates might contribute somewhat to this remaining task of explanation, but it is more likely that the basic character of community residential programs as novel, often volunteer-supported small-scale enterprises makes difficult any more definitive analysis. For example, facilities commonly receive

Table XVI. Accounting for variation in costs for adult halfway houses and community residences (transitional and nontransitional): results of a multiple regression: United States, 1976

Dependent Variable = Per Diem Cost[a]				
	Raw Beta (in dollars)	Standardized Beta	Contribution to Explained Variance (r square change)	F Score
House of paid staff time per resident...	$ .38	.39	.20	19.59*
In-House Counseling Services.....	1.41	.16	.03	3.02
External Facilitative Services.....	-1.18	-.21	.04	5.83*
Proportion of residents staying over 6 months.....	- .05	-.15	.02	2.63
(Constant).....	(9.28)	multiple r=.54		r^2=.29
Number of facilities reporting.....		118		

[a] Per diem based on total annual expenditures divided by the number of days of resident care provided for the year.

* $p < .05$

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

Table XVII. Selected correlation coefficients* for adult halfway houses and community residences (transitional and nontransitional): services, staffing, auspice, size, cost, and length of stay: United States, 1976

	Proportion of residents staying over 6 months	In-house counseling services	External counseling services	External facilitative services	Full-time staff hours per resident per week	Number of beds	Proprietary auspice
Per diem cost.....	-.24[b]	.27[c]	-.12	-.17[a]	.46[c]	-.17[a]	-.13
Proportion of residents staying over 6 months		-.35[c]	-.14	-.10	-.15	.30[c]	.46[c]
In-house counseling services.....			-.01	.26[c]	.20[a]	.03	-.22[b]
External counseling services.....				.58[c]	-.06	.16	.03
External facilitative services.....					-.01	-.04	-.13
Full-time staff hours per resident per week						-.21[a]	-.11
Number of beds.....							.32[c]

* Pearson zero order correlations.

a = p < .05

b = p < .01

c = p < .005

(The N for any given pair of variables in the above correlation ranges from 118 to 198. Calculations of levels of significance have been adjusted accordingly.)

Source: NIMH 1976 Inventory of Psychiatric Halfway Houses and Community Residences.

support services at reduced or no cost from volunteer or resident labor. Further, many regular employees in community residences receive relatively low wages and represent a quasi-volunteer labor pool. If labor inputs were adequately identified, estimates of real cost would probably rise, and cost variations among facilities might become more understandable. It also should be stressed that since no measures of program performance were available, assessing and comparing costs for often noncomparable programs has a restricted usefulness. Its primary value may lie in estimating baseline data for program planning. What does seem clear, however, is that community residences serve a large number of adults at relatively lower costs than hospitals.

COST FACTORS FOR FACILITIES SERVING CHILDREN AND ADOLESCENTS

Costs for juvenile programs are analyzed separately from those for adult facilities in order to provide a picture of factors influencing costs in each category of program. Descriptive data in the inventory showed facilities serving children and adolescents to be smaller, more likely to be licensed, more likely to provide additional in-house services, more likely to make more intensive use of staff, and more likely to be segregated by sex. These facilities, often affiliated with residential treatment centers and social service agencies, reported the highest average annual expenditure per admission — $15,000. The significantly higher per diem costs reported for juvenile facilities — $38, versus $16 for all other facilities ($t=3.42$, $p<.001$) — are attributable to several factors. On average, juvenile programs supported 21 staff hours per resident per week to an average of 15 hours for adult programs. Further, because facilities for juveniles are typically much smaller — both in numbers of beds and in number of residents — they may not benefit from economies of scale. The average number of beds was less than 15, contrasted with an average for other programs of over 30 beds ($t=3.14$, $p<.01$). Diseconomy of scale may occur through the indivisibility of various labor inputs required to provide the high level of services at juvenile facilities.

APPENDIX F

Definition of Geographic Regions and Population Size of Area

Geographic Region. The States are grouped into four geographic regions, which correspond to those used by the Bureau of the Census.

Region	States Included
Northeast	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania
North Central	Michigan, Ohio, Illinois, Indiana, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, Nebraska, and Kansas
South	Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, and Texas
West	Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California, Hawaii, and Alaska

United States includes the 50 States and the District of Columbia.

Population Size of Area

I. Urbanized area—consists of a central city, or cities, and surrounding closely settled territory whose population is generally delineated as residing in the following two specific criteria:
   1) Central City—population residing in a city of 50,000 or more inhabitants in 1970 or in twin cities, i.e., cities with contiguous boundaries and with a combined population of at least 50,000 inhabitants (with the smaller of the cities having a population of at least 15,000).
   2) Urban fringe—population residing in closely settled territory surrounding the central city or cities which includes principally:
      a. Incorporated places of 2,500 or more inhabitants
      b. Incorporated places of less than 2,500 inhabitants but each with closely settled area of 100 or more housing units
      c. Small land parcels of less than one square mile area with population densities of 1,000 or more inhabitants per square mile

II. Outside urbanized area—persons residing in incorporated or unincorporated places of 2,500 up to 50,000 inhabitants which are not part of urbanized areas.

III. Rural area—persons residing in incorporated or unincorporated places of less than 2,500 inhabitants which are not part of urbanized areas.

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